TOMPKINS COUNTY HEALTH DEPARTMENT
Your Partner for a Healthy Community

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AGENDA
Tompkins County Board of Health
Rice Conference Room
Tuesday, July 9, 2013
12:00 Noon

12:00 I. Call to Order

12:01 II. Privilege of the Floor – Anyone may address the Board of Health (max. 3 mins.)

12:04 III. Approval of June 11, 2013 Minutes (2 mins.)

12:06 IV. Financial Summary (9 mins.)

12:15 V. Old Business (15 mins.)

Administration	Children with Special Care Needs
Medical Director's Report	County Attorney's Report
Division for Community Health	Environmental Health

12:30 VI. New Business

12:30 ***Division for Community Health*** *(15 mins.)*

1. Approval of Licensed Home Care Services Agency (LHCSA) policy and procedure revisions:
   - Admission, Plan of Care and Discharge for Maternal-Child, MOMS Clients (5 mins.)
   - Client Services (5 mins.)
   - Medical Orders (5 mins.)

12:45 ***Administration*** *(30 mins.)*

Executive Session Discussion:

1. 2014 Budget Authorization

1:15 ***Adjournment***

Please call Shelley (274-6674) no later than 4:00 P.M.
on Monday, July 8th, if you do not plan to attend this meeting.

Board of Health
June 11, 2013
12:00 Noon
Rice Conference Room

Present: Will Burbank; Brooke Greenhouse; James Macmillan, MD, President; Michael McLaughlin, Jr.; Patricia Meinhardt, MD; and Janet Morgan, PhD

Staff: Sylvia Allinger, Director of CSCN; Liz Cameron, Director of Environmental Health; Sigrid Connors, Director of Patient Services; Brenda Grinnell Crosby, Public Health Administrator; Frank Kruppa, Public Health Director; Jonathan Wood, County Attorney; and Shelley Comisi, Keyboard Specialist

Excused: Amy DiFabio, MD; Patrick McKee; and William Klepack, MD, Medical Director

Privilege of the Floor: No one was present for Privilege of the Floor.

Dr. Macmillan called the regular meeting of the Board of Health to order at 12:07 p.m.

Approval of May 14, 2013 Minutes: Mr. Greenhouse moved to approve the minutes of the May 14, 2013 meeting as written; seconded by Dr. Morgan; and carried unanimously.

Financial Summary: Ms. Grinnell Crosby distributed the next iteration of charts and graphs of financial information. She reported conversations are continuing with Kevin Sutherland from County Administration to plan for the next version. Referring to the graph page, she stated the blue budget line is no longer a straight line calculated by adding 1/12th of the budget each month. It is now based on the average of the prior two years actual expenditures or revenues as a percent of the total applied to the current year's budget. Looking at the dashboard display page, she noted there is a significant amount of red color due to the percentages being utilized.

Mr. Kruppa added everything marked red is not a meaningful display of information so staff is working on some realistic benchmarks for the percentages. There needs to be valid ranges that will trigger attention and result in making adjustments. Depending on the time of year, the range of percentages change:

- First/Second quarters - anything within 10% of the budget above or below is green; 10-25% above is yellow; above 25% is red. It is not unusual for the budget to be off by 25% during this part of the year.
- Third quarter – anything within 10% above budget is green; 10-15% above is yellow; above 15% is red. As the year progresses, percentages should be moving closer to the budget.
- Last quarter – anything within 10% above budget is yellow; above 10% is red. The last three months should be close to the actual budget.

Discussion regarding the financial graphs/charts:

- Mr. Kruppa stated the budget is not 1/12th of each month so that calculation was replaced by one that uses historical data.
- Mr. McLaughlin said the graphs provide a quick visual and wondered about the usefulness of the dashboard.
- Mr. Kruppa explained the database is set up so the dashboard is the first warning system. If something appeared yellow or red, details would be provided to the Board.
- Ms. Grinnell Crosby stated she has requested a summary table of raw data enabling her to provide explanations.
- Dr. Meinhardt asked about confidence in the software program being utilized.
    - Ms. Grinnell Crosby responded Mr. Sutherland is working in Excel and importing data from the County financial system.
- Mr. Wood wondered if an assumption was being made that programs remain the same from year to year.
    - Mr. Kruppa replied programming has been consistent over the past few years except for the closing of the Certified Home Health Agency. He added there may be a need to adapt to growth and change.
- Mr. Greenhouse observed there could be times when the numbers may look better than they actually are.
    - Mr. Kruppa stated this is trial and error; adjustments can be made.
- Dr. Macmillan appreciated the historical data that he would not otherwise remember.
- Mr. McLaughlin added the data from the previous two years is a quick, clean way of identifying an issue.
- Ms. Grinnell Crosby pointed out the percentages could change with further analysis and understanding of historical data and past spending.
- Dr. Morgan requested the numbers on the dashboard display be changed to letters because having numbers suggest the four quarters of the year.

Administration Report: Mr. Kruppa reported:

- Beginning in July, the Board of Health (BOH) packet containing the agenda, minutes and supporting documents will be posted on the Health Department website. From the public standpoint, it is important to be able to reference items being discussed in the minutes. Having online access also raises questions about providing the packet to Board members. He requested feedback from the group which led to a discussion with the following main points:
    - The number of color graphs displaying program information is increasing. Issues to consider: color printing is costly and the size of files containing color items can create problems when transmitting by email.
    - Placing the color version of the packet on the website provides members the ability to download materials from the website rather than from an email.
    - A black and white paper version could be distributed at the meeting with attention paid to the challenges presented when producing color materials in black and white.

  - Ending the procedure of mailing the packet would save postage and processing time for staff.
  - Viewing the packet on individual laptops or the meeting room's projection screen during the meeting was considered but thought to have some downsides.
  - It was agreed that the July packet will be posted on the Health Department website, an email with the link will be sent to Board members, and a black and white paper copy of the packet will be provided to each member attending the meeting. The process can be modified as needed.
- Work on the Community Health Assessment (CHA) is ongoing. The completed survey had 266 respondents; over 100 identified themselves as community members. The Board and Legislature will be invited to help fine-tune the information gathered. The work session, tentatively scheduled for August, will be an opportunity for the Board to actively participate in the process.
- Mr. Kruppa displayed one of the framed copies of the Mission, Vision, and Values statements developed by Health Department staff as part of its Strategic Planning project. Ms. Grinnell Crosby and Administrative Coordinator Karen Johnson designed the layout and framed copies to hang in the lobby and in each of the conference rooms around the building. A considerable amount of work is being done to move forward with the scheduled activities for the year.

Medical Director's Report: Dr. Klepack was absent from the meeting.

Division for Community Health Report: Ms. Connors had nothing to add to her written report.

Children with Special Care Needs Report: Ms. Allinger distributed graphs and spreadsheets containing statistical highlights prior to the meeting. She had nothing to add to her report.

County Attorney's Report: Mr. Wood stated he had nothing to report.

Environmental Health Report: Ms. Cameron had nothing to add to her written report.

Dr. Meinhardt asked if there had been any feedback from the Guthrie/Geisinger group regarding its study of the health impacts of hydrofracking. Mr. Kruppa said the group had asked about accessing New York State data which the New York State Association of County Health Officials (NYSACHO) has supported; however, there has not been any direct contact with the Health Department.

Review of proposed 2014 Environmental Health (EH) Fees: Ms. Cameron referred to the 2014 fee packet and explained there were few changes as staff is in the process of implementing a new permit management software program. The project is expected to impact the way services are tracked and provided. Proposed fee changes include the addition of a plan review fee for push carts and an increase in public water supply fees to partially offset the cut in the drinking water grant. The water grant cut is about $8,000;

the increase in water supply fees would raise $2,000. It is unclear how the rest of the revenue will be recovered. Otherwise, the expected revenue is the same percentage as in previous years.

Highlights from the discussion on proposed EH fees:

- The water grant was part of a 5% cut of all grants.
- Surface water systems must meet more regulations than groundwater systems because they are larger and require more sampling and tracking. Staff inspects all systems once a year no matter the size.
- In terms of staff potentially handling more inspections, it was noted the number of water systems and restaurants has remained stable over the years with restaurants being the largest number of facilities inspected. There has been an increase in the number of temporary food inspections, but that is an area where procedures are changing to handle the increase.
- With the new software program, there will be significant changes regarding how EH operates that should increase staff efficiency.
- There is a philosophical discussion about whether or not the fee structure should be covering all costs. Staff is trying to put the most effective system together to ensure the least expensive way to provide services for the community.
- The push cart plan review is a new category. Formerly, push carts were considered a low risk plan review. Since there is a minimal level of review required, the category was created with a lower fee. Push carts are pre-designed, manufactured units such as ice cream carts.
- Staff provides extensive education to operators of temporary food establishments, e.g. chicken barbeques, with an emphasis on having food at the proper temperature to keep it safe for hours.

Potential rescheduling of future Board of Health Meetings: Mr. Kruppa explained the two reasons for requesting a change in meeting dates. (1) Health and Human Services Committee (HHS) meets the same day as BOH. Anything requiring legislative action needs to go through HHS before going to the full Legislature. Due to meeting schedules, it could be five weeks before the action reached the Legislature. (2) At present, there is insufficient time for staff to prepare the previous month's financial information for the Board's packet.

To gauge interest, Mr. Kruppa had sent an email to Board members listing the option of changing to the 3rd or 4th Tuesday of the month. Some members responded the 3rd Tuesday presented scheduling conflicts; therefore, the requested change is to move the BOH meeting from the 2nd to the 4th Tuesday of each month. Due to budget timing requirements, the new meeting date would begin in August.

Mr. Burbank, a member of HHS and the Legislature, advised there is a mechanism to bring important issues to a special meeting before the Legislature meets. He also noted committee scheduling is yearly so the monthly meeting date for HHS could change. Mr. Kruppa agreed that could happen, but is hopeful it would not be an issue. There remains the secondary problem of having enough time to gather accurate financial data for the Board.

Mr. Wood stated he has a standing meeting on the proposed 4th Tuesday so he would not arrive on time for the meeting. Ms. Grinnell Crosby reviewed the Bylaws and reported changing the meeting date does not require a change in the Bylaws, and there is no requirement that the County Attorney be present. Mr. McLaughlin proposed moving the meeting to 1:00 p.m., but Mr. Kruppa was unsure how that would impact staff. After listening to members, Dr. Macmillan noted the group would like the County Attorney present at the meeting. Mr. McLaughlin suggested the Board could defer any questions until Mr. Wood arrived.

Mr. McLaughlin made a motion that the BOH meeting be moved to noon on the 4th Tuesday of the month starting in August; seconded by Dr. Macmillan; and carried unanimously.

Adjournment: At 1:13 p.m. Dr. Macmillan adjourned the meeting.

Medical Director's Report
Board of Health
July 2013

General Activities:

- Reviewed the policies and procedures of the Community Health Advisory Committee.

- Discussed the use of influenza vaccine for the upcoming year with Karen Bishop. There is a four antigen flu vaccine which is being considered for approval. The ACIP (the committee responsible for advising the CDC on immunization practices) has not reviewed the four antigen vaccine yet to consider whether it should be used.

- Reviewed rabies orders.

- Reviewed items for Children with Special Care Needs.

- Attended June 18th meeting of the Community Health Advisory Committee. This committee reviews LHCSA policy and procedures, MOMS cases of problem patients, incidents and complaint reports, WIC reports, lead poisoning case reviews, audits of MOMS delivery of care and infection control reports.

  A number of interesting cases were brought up for community input.

- Gave input on upcoming Planned Parenthood STD contract for the next fiscal year. Addressed particularly desire for enhancing vaccination for STD's as well as documentation of information and discussions with patients regarding vaccination issues.

Public Health Interventions and Initiatives - When one has less how does one do more?

There are several constructs for viewing the impact and priority of public health actions. In 2010 the Director of the Centers for Disease Control and Prevention, Thomas R. Frieden, MD, MPH, published in the American Journal of Public Health | April 2010, Vol 100, No. 4 a pyramid construct which he thought most useful. This one I think has value in guiding our thinking as we try to get the most impact for the effort we spend. I thought that you as Board members would find it valuable as we all struggle to do as much as we can with the resources we have and as we wrestle with difficult decisions. See information below:

A Framework for Public Health Action: The Health Impact Pyramid

Thomas R. Frieden, MD, MPH
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Abstract

A 5-tier pyramid best describes the impact of different types of public health interventions and provides a framework to improve health. At the base of this pyramid, indicating interventions with the greatest potential impact are efforts to address socioeconomic determinants of health. In ascending order are interventions that change the context to make individuals' default decisions healthy, clinical interventions that require limited contact but confer long-term protection, ongoing direct clinical care, and health education and counseling.

Interventions focusing on lower levels of the pyramid tend to be more effective because they reach broader segments of society and require less individual effort. Implementing interventions at each of the levels can achieve the maximum possible sustained public health benefit.

LIFE EXPECTANCY IN DEVELOPED countries has increased from less than 50 years in 1900 to nearly 80 years today.

The greatest improvement occurred in the first half of the 20th century, when life expectancy in the United States and many parts of Europe increased by an average of 20 years,[2] largely because of universal availability of clean water and rapid declines in infectious disease,[3] as well as broad economic growth, rising living standards, and improved nutritional status.[4] Smaller gains in the latter half of the 20th century resulted primarily from advances in treatment of cardiovascular disease and control of its risk factors (i.e., smoking, high blood pressure, and high cholesterol).

The traditional depiction of the potential impact of health care interventions is a four-tier pyramid, with the bottom level representing population-wide interventions that have the greatest impact and ascending levels with decreasing impact that represent primary, secondary, and tertiary care.

[6] Other frameworks more specific to public health have been proposed. Grizzell's 6-tier intervention pyramid emphasizes policy change, environmental enhancement, and community and neighborhood collaboration.[7] Hamilton and Bhatti's 3-dimensional population health and health promotion cube incorporates 9 health determinants (e.g., healthy child development, biology and genetics, physical environments, working conditions, and social support networks)

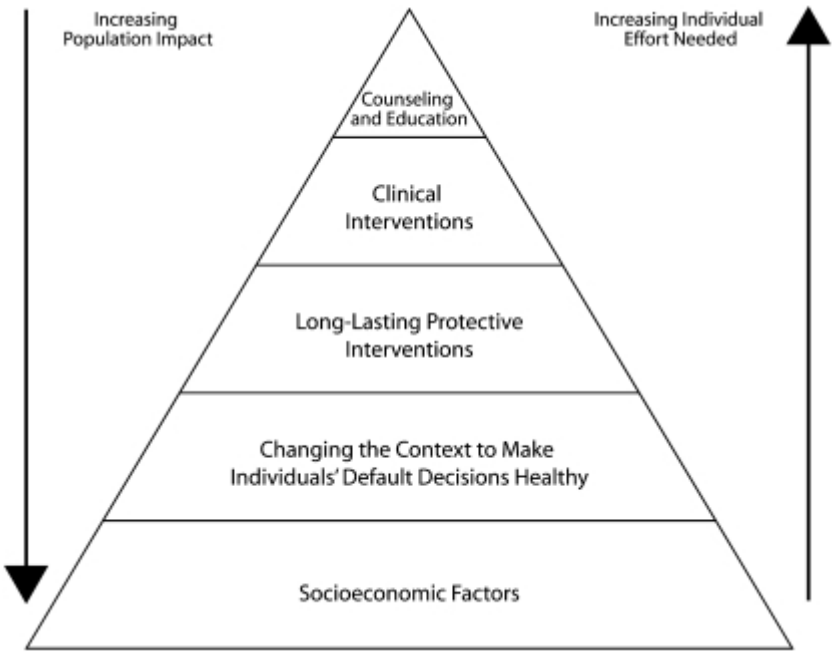
and evidence-based actions to address them (e.g., reorienting health services, creating supportive environments, enacting healthy public policy, and strengthening community action).[8] The maternal and child health pyramid of health services, developed by the US Health Resources and Services Administration, consists of 4 levels of services used by states to allocate resources for mothers and children.[6] Infrastructure building (e.g., monitoring, training, systems of care, and information systems) is at the bottom of the pyramid, followed by population-based services (e.g., newborn screening, immunization, and lead screening) and enabling services (e.g., transportation, translation, case management, and coordination with Medicaid), with direct health care services at the top.

All of these models, however, focus most of their attention on various aspects of clinical health services and their delivery and, to a lesser extent, health system infrastructure. Although these are of critical importance, public health involves far more than health care. The fundamental composition, organization, and operation of society form the underpinnings of the determinants of health, yet they are often overlooked in the development frameworks to describe health system structures. As a result, existing frameworks accurately describe neither the constituent elements nor the role of public health.

FIVE-TIER PYRAMID

An alternative conceptual framework for public health action is a 5-tier health impact pyramid (Figure 1). In this pyramid, efforts to address socioeconomic determinants are at the base, followed by public health interventions that change the context for health (e.g., clean water, safe roads), protective interventions with long-term benefits (e.g., immunizations), direct clinical care, and, at the top, counseling and education. In general, public action and interventions represented by the base of the pyramid require less individual effort and have the greatest population impact. However, because these actions may address social and economic structures of society, they can be more controversial, particularly if the public does not see such interventions as falling within the government's appropriate sphere of action.

FIGURE 1 **The health impact pyramid.**



Interventions at the top tiers are designed to help individuals rather than entire populations, but they could theoretically have a large population impact if universally and effectively applied. In practice, however, even the best programs at the pyramid's higher levels achieve limited public health impact, largely because of their dependence on long-term individual behavior change.

[9] As Rose writes,

Personal life-style is socially conditioned. Individuals are unlikely to eat very differently from the rest of their families and social circle. It makes little sense to expect individuals to behave differently than their peers; it is more appropriate to seek a general change in behavioral norms and in the circumstances which facilitate their adoption.

[10](p135)

Socioeconomic Factors

The bottom tier of the health impact pyramid represents changes in socioeconomic factors (e.g., poverty reduction, improved education), often referred to as social determinants of health, that form the basic foundation of a society.

[11,12] Socioeconomic status is a strong determinant of health, both within and across countries. [13] Although the exact mechanisms by which socioeconomic status exerts its effects are not always apparent, poverty, low educational attainment, relative deprivation, and lack of access to sanitation increase exposure to environmental hazards.[14] Educational status is also tightly correlated with cardiovascular risk factors, including smoking. [15, 16]

Although poverty increases ill health within a society, economic development can also increase illness and death from noncommunicable disease. As living standards and life expectancy improve, risk for cardiovascular disease and some cancers increases.

[17] Much of this increase results from modifiable risk factors related to overconsumption of tobacco, unhealthy food, and alcohol, with a concurrent decrease in physical activity. Greater wealth can also lead to more roads and an increase in motor vehicle use, which can result in increased outdoor air pollution and more injury and death from traffic crashes.

A third of the world's urban population lives in slums.

[18] Substantial health improvements in high-poverty areas will require improved economic opportunities and infrastructure, including reliable electric power, sanitation, transport, and other basic services. [19] Clean water and improved sanitation introduced in the United States in the late 19th and early 20th centuries may have been primarily responsible for reducing mortality rates by about half and child mortality rates by nearly two thirds in major cities. [20] Still, more than 900 million people worldwide have no access to clean drinking water and about 2.5 billion have no access to adequate sanitation.[21] As the World Health Organization's Commission on Social Determinants of Health reported, “Social injustice is killing people on a grand scale.” [11](p26)

Changing the Context to Encourage Healthy Decisions

The second tier of the pyramid represents interventions that change the environmental context to make healthy options the default choice, regardless of education, income, service provision, or other societal factors. The defining characteristic of this tier of intervention is that individuals would have to expend significant effort not to benefit from them. For example, fluoridated water—which is difficult to avoid when it is the public supply—not only improves individual health by reducing tooth decay, [22] but also provides economic benefits by reducing health spending and productivity losses. In countries without either adequate natural or added fluoridation, health authorities are limited to counseling interventions, such as encouraging tooth brushing.

Other contextual changes that create healthier defaults include clean water, air, and food; improvements in road and vehicle design; elimination of lead and asbestos exposures; and iodization of salt.

[22] The potential societal impact of decreasing cardiovascular risk factors by changing from saturated to unsaturated cooking oils was demonstrated in Mauritius[23]; eliminating artificial *trans* fat in food is another way to prevent cardiovascular disease. [24] Strategies to create healthier environmental contexts also include designing communities to promote increased physical activity; enacting policies that encourage public transit, bicycling, and walking instead of driving; designing buildings to promote stair use; passing smoke-free laws; and taxing tobacco, alcohol, and unhealthy foods such as soda and other sugar-sweetened beverages.

Cardiovascular disease risk factors (e.g., hypertension) are currently addressed at the individual level through screening and medication. But even assuming perfect treatment, this approach fails to prevent almost half of the disease burden caused by elevated blood pressure; cardiovascular risk increases with systolic blood pressure above 115 mm Hg, a level at which medical treatment is not recommended currently.

[25, 26] Changing the environmental context so that individuals can easily take heart-healthy actions in the normal course of their lives can have a greater population impact than clinical interventions that treat individuals.

For example, modern diets contain many times the minimum daily requirement of sodium—mostly from packaged foods and restaurant meals—making it difficult for individuals to control their intake.

[27] Reducing dietary sodium can reduce hypertension at the population level. [28, 29] A healthier food environment can be created by decreasing salt in packaged foods. This is happening in the United Kingdom, which introduced four-year sodium reduction targets,[30] and in Finland, where dietary sodium intake decreased approximately 25% in the past 30 years. [31]

Long-Lasting Protective Interventions

The third level of the pyramid represents 1-time or infrequent protective interventions that do not require ongoing clinical care; these generally have less impact than interventions represented by the bottom 2 tiers because they necessitate reaching people as individuals rather than collectively. Historic examples include immunization, which prevents 2.5 million deaths per year among children globally.

[32] Another example is colonoscopy, which can significantly reduce colon cancer and is only needed every 5 to 10 years for most people. Smoking cessation programs increase quit rates; life expectancy among men who quit at age 35 is almost 7 years longer than for those who continue to smoke. [33]

Male circumcision, a minor outpatient surgical procedure, can decrease female-to-male HIV transmission by as much as 60%.

[34] Scale-up could potentially prevent millions of HIV infections in sub-Saharan Africa. [35, 36] A single dose of azithromycin or ivermectin can reduce the prevalence of onchocerciasis, a major cause of blindness.

Clinical Interventions

The fourth level of the pyramid represents ongoing clinical interventions, of which interventions to prevent cardiovascular disease have the greatest potential health impact. Although evidence-based clinical care can reduce disability and prolong life, the aggregate impact of these interventions is limited by lack of access, erratic and unpredictable adherence, and imperfect effectiveness. Access can be limited even in systems that guarantee health coverage for all

[38] and is a much greater problem in the United States and other countries without universal health care coverage. [39, 40] Nonadherence is especially problematic for chronic conditions that are usually asymptomatic, such as hypertension, hyperlipidemia, and diabetes. At least a third of patients do not take medications as advised, and nonadherence cannot be predicted from socioeconomic or demographic characteristics. [41, 42]

Rigorous accountability, incentives for meaningful outcomes (e.g., blood pressure and cholesterol control), and systems to enable improved performance are all essential to improve health care system performance. Electronic health records have the potential—if and only if they are implemented with prevention and accountability as guiding principles—to facilitate greatly improved preventive and chronic care.

[43] This goal is more likely to be attained if electronic record keeping is implemented along with changes in both financial incentives and physician practices to proactively support preventive care and control of chronic diseases. [44]

Counseling and Educational Interventions

The pyramid's fifth tier represents health education (education provided during clinical encounters as well as education in other settings), which is perceived by some as the essence of public health action but is generally the least effective type of intervention.

[9] The need to urge behavioral change is symptomatic of failure to establish contexts in which healthy choices are default actions. For example, counterbalances to our obesogenic environment include exhortations to increase physical activity and improve diet, which have little or no effect. More than one third of US adults, or 72 million people, were obese in 2006, a dramatic increase over 1980. [45] Two thirds of these individuals were counseled by a health care provider to lose weight, [46] yet daily calorie and fat intake continues to rise.

Counseling, either within or outside the clinical context, is generally less effective than other interventions; successfully inducing individual behavioral change is the exception rather than the rule. For example, although clear, strong, and personalized smoking cessation advice, even in the absence of pharmacological treatment, doubles quit rates among smokers who want to stop and should be the norm in medical care, it still fails to help 90% of those who are motivated to quit.

[47, 48]Nevertheless, educational interventions are often the only ones available, and when applied consistently and repeatedly may have considerable impact. An example of a successful evidence-

based educational intervention is trained peer counselors advising men who have sex with men about reducing HIV risk.

[49]

PROGRAM IMPLEMENTATION

Comprehensive tobacco control programs, which contain elements that work at all levels of the pyramid, illustrate the potential application of this paradigm and the synergies among different levels of intervention. People with low incomes and low educational attainment have higher rates of smoking than do people with higher incomes and education.

[50] Interventions that address social determinants of health, such as increasing a population's educational and economic status, should therefore reduce smoking rates. However, because these changes often require fundamental social change, they are generally not within the traditional purview of tobacco control or public health programs.

Context-changing interventions, such as increasing tobacco taxes, establishing smoke-free workplaces, and changing the social norms regarding smoking through hard-hitting antitobacco campaigns and elimination of advertising and promotional cues to smoke, are highly effective in reducing tobacco use.

[51] Hard-hitting ad campaigns, particularly as part of a comprehensive tobacco control program, not only reduce tobacco use by changing the social context of smoking[52] but also provide in effect a social immunization against smoking that persists over time. Clinical care that includes cessation medications can triple quit rates in individual smokers, but even the best systems treat only a small proportion of smokers, and only one third of those who are motivated to quit and are treated will succeed. [48] Education about the harms of smoking provides people with information to help them change their behavior. Other examples of this 5-tiered framework applied to communicable disease, chronic disease, and injury prevention are given in Table 1. Inevitably, some programs blur the distinctions between tiers. For example, mass media campaigns for tobacco control could be viewed as an educational intervention (tier 5), but if done effectively, such actions can change the context by altering the social norms related to tobacco use (tier 2).

TABLE 1

Structural Approaches to Health Promotion for Communicable Disease, Noncommunicable Disease, and Injury Prevention

Approaches to Prevention	Communicable Disease	Noncommunicable Disease	Injuries
Counseling and	Behavioral counseling to reduce	Dietary counseling	Counseling and public education

Approaches to Prevention	Communicable Disease	Noncommunicable Disease	Injuries
educational interventions	sexually transmitted infections	Counseling to increase levels of physical activity Public education about avoiding lifestyle-mediated disease	to avoid drinking and driving and encourage compliance with traffic laws School-based programs to prevent or reduce violent behavior
Clinical interventions	HIV treatment to decrease viral load and reduce transmission Treatment of tuberculosis, resulting in decreased spread of infection	Treatment of hypertension and hyperlipidemia Aspirin therapy for people with coronary heart disease	Methadone and buprenorphine treatment to decrease opiate overdose Screening and treatment of women older than 65 years for osteoporosis to reduce fractures
Long-lasting protective interventions	Immunizations Male circumcision in countries with high HIV prevalence and significant female-to-male transmission Mass antibiotics to prevent or treat tropical diseases (e.g., onchocerciasis)	Colonoscopy Treatment of tobacco addiction Surgical sterilization, intrauterine device insertion, or other long-acting contraception to reduce maternal mortality Dental sealants	Brief behavioral counseling to reduce alcohol consumption Home modification, such as installation of grab bars and handrails, to prevent falls among the elderly
Changing the context	Clean water Reduced indoor smoke pollution from biomass cooking Ubiquitous condom availability	*Trans* fat elimination in processed food to reduce cardiovascular disease Sodium reduction in packaged foods and food served in restaurants to reduce cardiovascular disease Fluoridation of water to prevent dental cavities Elimination of lead paint and asbestos exposures Increased unit price for tobacco, alcohol, and sugar-sweetened beverages Smoke-free workplaces Community and transit design to promote greater physical activity	Road and vehicle design requirements to reduce crashes and protect pedestrians and bicyclists Laws prohibiting the sale of alcohol to minors and increased alcohol price Laws prohibiting driving at even low blood alcohol levels Effectively implementing laws to mandate helmet use by motorcyclists and motorcycle passengers Occupational safety requirements
Socioeconomic factors	Reduced poverty to improve immunity, decreased crowding and environmental exposure to communicable microbes, and	Reduced poverty, increased education levels, and more nutritional options to reduce cardiovascular disease, some	Reduced poverty levels to reduce drug use and violence, improved housing options, and lowered vulnerability to extreme

Approaches to Prevention	Communicable Disease	Noncommunicable Disease	Injuries
	improved nutrition, sanitation, and housing	cancers, and diabetes	weather conditions

PRACTICAL APPLICATION OF THE HEALTH IMPACT PYRAMID

The health impact pyramid, a framework for public health action, postulates that addressing socioeconomic factors (tier 1, or the base of the pyramid) has the greatest potential to improve health. Interventions that change the context for individual behavior (tier 2) are generally the most effective public health actions; 1-time clinical interventions (tier 3), such as immunizations, can be more effectively applied than those requiring ongoing care; and clinical interventions (tier 4) are generally, although not inevitably, more effective than counseling and education (tier 5).

Although the effectiveness of interventions tends to decrease at higher levels of the pyramid, those at the top often require the least political commitment. Achieving social and economic change might require fundamental societal transformation. Contextual change is often controversial, as evidenced by disputes over smoke-free laws, restrictions on artificial *trans* fat, and water fluoridation.

[53], [54] One-time interventions tend to be less controversial, although immunization programs that attempt to reach all members of a society often meet resistance arising from suspicion and disbelief. [55]Although the structure and financing of health care systems can be controversial, clinical care itself rarely is. While exceptions exist, health education usually requires minimal political backing. Hence the greater popularity of school-based antismoking programs (despite consistent evidence they provide little to no benefit[56]) than of proven tobacco control interventions such as taxation, smoke-free environments, and comprehensive marketing bans. Similarly, exhorting people to exercise more and eat less is politically popular, but taxation of soda and other sugar-sweetened beverages, [57] bans on marketing junk food to children, and community redesign to encourage walking and bicycling, although far more effective, are also politically more difficult.

Interventions that address social determinants of health have the greatest potential public health benefit. Action on these issues needs the support of government and civil society if it is to be successful.

[58] The biggest obstacle to making fundamental societal changes is often not shortage of funds but lack of political will; the health sector is well positioned to build the support and develop the partnerships required for change. [59]

To say that social and contextual changes are more effective at improving public health is not to imply that other interventions should be ignored. For different public health problems, different interventions may be the most effective or feasible in any given context. Education to encourage condom use, although of only limited effectiveness, can reduce HIV transmission and save lives. Changing the context to make condoms ubiquitously available and acceptable makes education about their use more effective. Comprehensive public health programs should generally attempt to implement measures at each level of intervention to maximize synergy and the likelihood of long-term success.

Acknowledgments

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TOMPKINS COUNTY HEALTH DEPARTMENT
Your Partner for a Healthy Community

Frank Kruppa
Public Health Director
55 Brown Road
Ithaca, NY 14850-1247

Division for Community Health Highlights for July 9, 2013 BOH Meeting

Sigrid Larsen Connors, Director of Patient Services

Note – Action agenda and supporting documents are now placed at front of Division packet

Administration

- The Division welcomed Dr. Doug MacQueen as the new Tuberculosis Consultant for the TB Control Program.
- Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP):
  - Planning meetings held June 4, 10 and 28.
  - Attended HANY hosted webinars *NYS Prevention Agenda: Identifying Community Health Needs and Priorities* on June 10 and *Applying the Science of Improvement on* June 17.
- WIC –
  - Met with NYSDOH WIC Regional representatives to review March Site Visit, June 13. Action items identified and plan of improvement implemented. Reviewed budget expectations for fiscal year beginning October 1, 2013.
  - Received Budget Call Letter June 25 for last year of five-year grant cycle beginning October 1, 2013.
  - The Request for Applications for WIC sponsorship fiscal term October 1, 2014 through September 30, 2019 is expected to arrive in the next several months.
  - DPS continues to cover for WIC Director on part-time leave.
- Convened the quarterly Community Health Quality Assurance Committee meeting, June 18. Committee approved three revised Licensed Home Care Service Agency (LHCSA) policies.
- Attended teleconferences/webinars on potential software solutions with Software Search Team, June 4, 6 and 20.
- $151,250 Capital Project for Software Replacement requested for 2014 county budget.
  - The software replacement capital project will provide a centralized solution for the management of all processes, information and billing requirements related to the service areas of this division primarily focused on immunizations, TB screening, maternal and child health and home visits. The outcome of the project will replace the software implemented in 2003 which was specific to the previous use of managing services offered under the CHHA. After a thorough review with the current software vendor, it was determined that this software is not capable of meeting the needs for the remaining Division services.
- Sent $40,000 NYSDOH grant application – *Technological Support for Immunization Billing Implementation* with Jennifer Grier, Senior Account Clerk Typist as project lead, June 28. If awarded, these funds will offset the capital request.
- Responded to 14 requests for public health information during 2nd Quarter.
- Developed and completed Division 2014 county budget request during last two weeks of June.

Staffing

- Oriented a new employee June 4 and completed one staff annual performance evaluation, June 5.
- Welcomed Theresa Lyczko, Director of the Health Promotion Program to the 25 Year Club, June 6!

Emergency Preparedness

- Attended monthly NYSACHO meeting via teleconference on the *LHD Public Health Emergency Preparedness Deliverables for 2013-2014,* June 6.
- Completed updates for Division maintenance information June 20.

Communicable Disease Reports – May 2013 monthly and annual statistics attached.

Division Statistical Highlights – January – May 2013 reports attached.

COMMUNITY HEALTH SERVICES
Karen Bishop, Community Health Nurse Supervisor
Report for June

Staffing – One half-time (17.5 hours/week) Community Health Nurse remained vacant. Duties continue to be reassigned to other staff nurses.

Communicable Disease – See attached statistical reports.

Immunizations – Immunization audits of 2 and 17 year old records was conducted at two family practice provider offices in June with results shared face to face with each office. Both offices manually enter immunizations into NYSIIS as their electronic medical record does not yet communicate with NYSIIS. Provided each office with a list of children missing immunizations, the providers used the list to make appointments to get the children caught up. Staff plans to rerun the audit reports to show the provider improvement. Eleven provider audits completed April through June.

Lead Poisoning – (3 active cases)
#1 case: 22 month old with blood lead level 65 mcg/dL on 4/25/13 requiring immediate hospitalization for chelation. Blood lead level dropped to 35 mcg/dL prior to hospital discharge. Complex psychosocial history including extended family member with custody of the child, the child spends time with multiple family members in two counties. The child has Pica, an eating disorder. Of the three family residences, only one in a neighboring county was found lead safe. The other two residences had visible evidence of chewed window sills, door casings, baseboards and crib rails down to the bare wood. Landlords of these two residences were issued notice and demand letters by Environmental Health necessitating certified lead safe contractors remediate before the child is allowed to return. Lead safe housing was found for the extended family member in Tompkins County as of 6/5/13. Child Protective Services is involved in the case.
Plan: Continue lead case management services shared between counties.

#2 case: Two year old with initial blood lead level 13 mcg/dL on 5/23/13. Family live in an 1800's house they are remodeling. Father was grinding paint in the home and lead paint/dust was found in multiple areas in the home. All household members were tested. Sibling's blood lead level was 11.0.

No lead hazards were found in their day care location. Parents educated regarding lead and immediately stopped grinding paint.
Plan: Keep both cases open until blood lead levels meet discharge criteria.

#3 case: Three year old with initial blood lead level 12 mcg/dL on 8/17/12. Child had not accessed medical care prior to the 8/17/12 office visit. Developmental and behavior abnormalities identified. Referred child for developmental services but parent has resisted to date. Child missed three follow up provider office appointments. The lead nurse continued outreach to the parent to encourage medical and developmental follow-up. No repeat blood level has been drawn since the initial blood lead level. Parent is recently unemployed and without a phone.
Plan: Case reported to Child Protective Services for neglect. Keep case open to monitor repeat blood lead level and link to medical and developmental services.

Tuberculosis (TB) – 2 active cases

TB Disease – Pulmonary – No Drug Resistance

- 21 year old female, foreign born, identified in October 2012. Has been receiving Direct Observe Therapy (DOT) since October 2012 and has adhered to treatment regime. Patient became pregnant in January and treatment plan was reviewed with TCHD TB medical consultant. No changes were made to TB drug treatment regime. Plan: Continue intermittent therapy with DOT three times per week. Estimated treatment completion is July 2013.

TB Disease – Pulmonary – Drug Sensitivities Pending

- 17 year old female, born in U.S., spent 10 years in Korea, identified in May 2013. Receiving DOT and tolerating well. Contact investigation ongoing. Plan: Continue DOT five times per week. Adjust treatment as needed pending drug sensitivities.

HEALTH PROMOTION PROGRAM
Theresa Lyczko, Director

Tobacco Control Program

- Published letter to the Editor of *Ithaca Journal*, "Smoke Free Parks Allow Enjoyment for All," May 22. Samantha Hillson, Tobacco Education Coordinator
- Central Region all partners meeting in Utica, May 23. Ted Schiele, Planner/Evaluator
- World No Tobacco Day activity at Green Street Pharmacy, downtown Ithaca. Conducted a "dot survey" for which 28 participants responded to the question, "Should drug stores and pharmacies sell tobacco?" Approximately 12 signature cards were also collected in support of Green Street Pharmacy's No Tobacco policy, May 31. Samantha Hillson, Ted Schiele
- Correspondence with Town of Ithaca regarding tobacco free policy, May 29; correspondence with New Roots Charter School about tobacco free initiative with students, June 14. Samantha Hillson
- Press release for World No Tobacco Day activities sent May 24, with event brief sent May 29. Ted Schiele
- Attended Cayuga Medical Center tabling in celebration of the one year anniversary of their tobacco free campus policy, May 31. Ted Schiele, Samantha Hillson
- Meeting with "Ordinance Review" working group May 28. The group will determine how to evaluate the Ithaca Ordinance that regulates outdoor smoking as required by resolution included in the law, and how to improve its effectiveness. The group includes 3 Common Council members, and the Downtown Ithaca Alliance representative. Ted Schiele, Samantha Hillson

- Meeting with staff of Paleontological Research Institution (PRI), regarding the establishment of a tobacco free property policy for PRI, Museum of the Earth, and Cayuga Nature Center, June 13. Ted Schiele, Samantha Hillson
- Communication with Broome County "Reality Check" tobacco program to collaborate on Girl Scout initiative, June 12. Samantha Hillson
- Correspondence with Girl Scouts of NYPENN to create resource guide on tobacco control initiatives for troop leaders, June 6, 14. Samantha Hillson
- Delivered Smoke-Free Property signs to the East Hill Flying Club, June 13. Ted Schiele
- Conference Call: Media Workgroup, June 4. Ted Schiele
- Conference Calls: Tobacco Free Pharmacy Workgroup, June 14; Monthly Point of Sale June 11; Technical Assistance call on Clean Indoor Air Act (CIAA) 10th anniversary publicity, June 4, 17. Ted Schiele, Samantha Hillson
- Correspondence with staff at Rural Youth Services, June 19 and Ithaca Youth Bureau, June 18 to plan for fall activities, June 18. Samantha Hillson

TCHD Participation and Support

- TCHD all-staff meeting, June 7. Susan Dunlop, Community Health Nurse, Theresa Lyczko, Ted Schiele, Samantha Hillson
- Coordinated WHCU monthly interview on News Talk. Assisted Anne Wildman with preparation to discuss EH's role in food safety during Tompkins County's many festival and outdoor food events. Aired June 12. Theresa Lyczko

<u>Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP)</u>

- Viewed Hospital Association of New York State (HANYS) webinar on preparation of CHA and hospital Community Service Plan, June 3. Theresa Lyczko
- Met with Director of Patient Services and Public Health Director for bi-weekly progress report, June 4, 10. Theresa Lyczko
- Prepared and presented community survey results to Health Planning Council (HPC) Board, June 10. Theresa Lyczko
- Community survey analysis for presentations, Ted Schiele, Theresa Lyczko, Samantha Hillson
- Attended and developed PowerPoint for June 10 HPC presentation and handouts. Ted Schiele. Attended and took notes, Samantha Hillson, attended, Susan Dunlop

Web site postings

- Met with Public Health Director and staff regarding plans to post full BOH packet online June 14.
- Lyme disease updates: tick submission form, state factsheet, and case count chart June 19.
- BOH agenda, minutes; EH highlights; WIC income guidelines

Community Outreach

- Creating Healthy Places (CHP) Wellness committee meetings at six different work sites, June 4, 10, 12, 13, and two on June 18. Ted Schiele. June 12, Samantha Hillson
- Met with COPD committee to finalize topics for the six – part Chronic Obstructive Pulmonary Disease educational series open to Tompkins County residents, June 3. Program to begin September 12. Susan Dunlop
- Phone conference with presenter to discuss advance directives at COPD educational sessions, June 18. Susan Dunlop
- Met with two local health care providers to promote the Diabetes Prevention Program (DPP), June 12, 19. Susan Dunlop

- Met with Health Planning Council staff to review DPP curriculum in preparation for July class, June 12. Susan Dunlop
- Prepared DPP promotional information for upcoming classes to listserv, June 24. Susan Dunlop, Theresa Lyczko
- NYSDOH webinar (1.5 hours) on data gathering and reporting for DPP, June 6. Theresa Lyczko, Susan Dunlop

Meetings and Trainings

- Community Coalition for Healthy Youth committee meetings: May 28, Ted Schiele, Samantha Hillson. June 3, 10, 19. Ted Schiele
- Attended the Chronic Disease Self Management (CDSMP) peer leader quarterly meeting. Recertified as a peer leader for CDSMP and the Diabetes Self Management Program (DSMP), June 13. Susan Dunlop
- Childhood Obesity, T2B2, 1.0 hours, May 30. Susan Dunlop
- Take Your Best Shot: Injection Safety, T2B2, 1.0 hours, May 30. Susan Dunlop
- Completed FEMA courses: IS-100, May 30; FEMA IS-700, June 7; IS-800, June 18. Samantha Hillson
- Completed Defensive Driving Course, June 19. Samantha Hillson

WIC – no narrative report – see attached WIC Dashboard

ATTACHMENTS

- May 2013 Division Statistical Highlights
- May 2013 Summary of DC103s by Disease
- 2013 Communicable Diseases Summary Report
- WIC Dashboard for July BOH Meeting

Division for Community Health

Clinic Statistical Highlights 2013

Community Health Services	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	YTD 2013	YTD 2012	Total 2012
Clinics															
# of Immunization Clients	25	20	21	13	15								**94**	170	411
# of Immunizations Given	29	37	27	21	20								**134**	230	574
Children 0 - 19 yrs.	14	34	12	15	10								**85**	122	295
Adults 20 yrs. & over	15	3	15	6	10								**49**	108	279
# of Flu Immunizations	2	0	0	0	0								**2**	19	916
Rabies Vaccination Program															
Post-Exposure Clients	1	1	1	2	9								**14**	29	103
Post-Exposure Vaccinations	3	2	4	6	19								**34**	47	282
Tuberculosis Program															
Cumulative Active TB clients	2	2	2	2	3								**3**	3	5
Active TB Admissions	0	0	0	0	1								**1**	3	5
Active TB Discharges	1	0	0	0	0								**1**	1	3
Cumulative Latent TB Infection Clients	33	33	34	37	37								**37**	63	93
Latent TB Infection Admissions	3	0	1	3	0								**7**	21	51
Latent TB Infection Discharges	1	2	2	4	5								**14**	20	54
TB Direct Observe Therapy Visits	21	16	13	13	52								**115**	126	415
# of PPDs	25	40	58	20	16								**159**	155	474
Anonymous HIV Clinics															
# of HIV Clinics - including Walk-Ins	7	5	5	5	6								**28**	36	74
# of Counseled & Tested	10	6	7	7	8								**38**	64	120
HIV+ Eliza & Western Bloc	0	0	0	0	0								**0**	0	1
				Final	Prelim										
WIC	Jan	Feb	Mar	April	May										
Total Enrolled (average)	1806	1799	1793	1758	1777								**1787**	1740	1781
Total # Served (average)	1545	1555	1546	1533	1506								**1537**	1501	1519
% Caseload Target (avg) *2000 FY12	79.50%	77.75%	77.30%	76.65%	75.30%								**1**	75.01%	75.97%
Monthly Clinic No-Show Rate (% avg.)	11.96%	13.56%	13.77%	12.80%	15.25%								**0**	13.73%	15.20%
# of Clinics	21	23	21	22	22								**109**	98	267

All statistics are considered primary as data is continually collected and updated

UA = Unavailable at this Time

Maternal Child Services/MOMS program	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	YTD 2013	YTD 2012	Total 2012
Cumulative Unduplicated Client Count	186	216	238	269	307								**307**	157	346
# of Admissions	37	30	22	31	38								**158**	152	341
# of Discharges	37	18	35	22	34								**146**	165	375
Total # of Office Visits	**31**	**31**	**30**	**34**	**36**								**162**	**139**	**332**
# of Antepartum Home Visits	46	40	42	50	37								**215**	146	493
# of Postpartum Home Visits	31	17	34	22	37								**141**	130	306
# of Pediatric Home Visits	14	16	11	8	9								**58**	14	56
Total # of Home Visits	**91**	**73**	**87**	**80**	**83**								**414**	**290**	**855**
Total # of Home & Office Visits	**112**	**104**	**117**	**114**	**119**								**566**	**429**	**1187**
# of RN Home Visit Hours	89	66	83	78	81								**397**	308	865
# of Childbirth Education Classes	2	1	0	3	0								**6**	0	6
# of Childbirth Education Moms	8	5	0	12	0								**25**	0	20
On Call Visits															
Maternal Child On Call Visits	0	0	0	0	1								**1**	3	3
Rabies On Call Vaccinations	0	1	0	1	2								**4**	9	39
TB Direct Observe Therapy On Call Visits	0	0	0	0	3								**3**	0	7

2013 Log of Public Contacts* (Via Telephone or Email) For Community Health Services													**2013 Total**	**2012 Total**	**2011 Total**
Communicable Disease (including Flu/Pneumonia disease related, HIV, Rabies and TB)	160	266	82	142	189								**839**	2182	2004
Immunization (including Flu)	119	57	73	109	95								**453**	1460	1921
Maternal Child/Family/MOMS	112	57	286	405	383								**1243**	4127	3906
Miscellaneous	27	29	34	63	61								**214**	472	535
Total	**418**	**409**	**475**	**719**	**728**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**2749**	8241	8366

*2012 and prior Public Contacts include Home Care Program calls. Home care program closed in May 2012.

All statistics are considered preliminary as data is continually collected and updated.

UA = Unavailable at this time

TOMPKINS COUNTY, N.Y.

2013 Communicable Disease Report

DISEASE	2012 TOTALS	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	2013 TOTALS
AIR-BORNE ENVIRONMENTAL DISEASE	2	0	0	0	0	0	0	0	0	0	0	0	0	0
LEGIONELLOSIS	2	0	0	0	0	0	0	0	0	0	0	0	0	0
ARTHROPODA-BORNE DISEASES	21	0	0	1	1	1	0	0	0	0	0	0	0	3
ANAPLASMOSIS	0	0	0	0	0	0	0	0	0	0	0	0	0	0
BABESIOSIS	1	0	0	0	0	0	0	0	0	0	0	0	0	0
*LYME DISEASE	20	0	0	1	0	1	0	0	0	0	0	0	0	2
MALARIA	0	0	0	0	1	0	0	0	0	0	0	0	0	1
BLOODBORNE DISEASES	82	6	6	8	7	8	0	0	0	0	0	0	0	35
HEPATITIS C, ACUTE	5	0	0	0	0	0	0	0	0	0	0	0	0	0
HEPATITIS C, CHRONIC	77	6	6	8	7	8	0	0	0	0	0	0	0	35
CENTRAL NERVOUS SYSTEM DISEASES	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MENINGITIS, BACTERIAL	0	0	0	0	0	0	0	0	0	0	0	0	0	0
GASTROINTESTINAL ILLNESSES	74	4	2	5	8	5	0	0	0	0	0	0	0	24
BACTERIAL	42	1	1	4	7	3	0	0	0	0	0	0	0	16
CAMPYLOBACTERIOSIS	21	0	1	2	4	1	0	0	0	0	0	0	0	8
E. COLI 0157:H7	2	0	0	0	0	0	0	0	0	0	0	0	0	0
LISTERIOSIS	1	0	0	0	0	0	0	0	0	0	0	0	0	0
SALMONELLOSIS	14	1	0	2	3	0	0	0	0	0	0	0	0	6
SHIGELLOSIS	3	0	0	0	0	1	0	0	0	0	0	0	0	1
YERSINIOSIS	1	0	0	0	0	1	0	0	0	0	0	0	0	1
PARASITIC	32	3	1	1	1	2	0	0	0	0	0	0	0	8
AMEBIASIS	1	1	0	0	0	0	0	0	0	0	0	0	0	1
CRYPTOSPORIDIOSIS	12	1	1	0	1	2	0	0	0	0	0	0	0	5
CYCLOSPORIASIS	1	0	0	0	0	0	0	0	0	0	0	0	0	0
GIARDIASIS	18	1	0	1	0	0	0	0	0	0	0	0	0	2
MYCOBACTERIUM AGENTS	4	0	0	0	0	1	0	0	0	0	0	0	0	1
TUBERCULOSIS	4	0	0	0	0	1	0	0	0	0	0	0	0	1
RABIES EXPOSURE	108	2	2	3	2	9	0	0	0	0	0	0	0	18
ADMINISTERED @ TCHD	96	1	1	3	2	9	0	0	0	0	0	0	0	16
ADMINSTERED @ GANNETT	12	1	1	0	0	0	0	0	0	0	0	0	0	2
SEXUALLY TRANSMITTED DISEASES	319	29	21	31	26	20	0	0	0	0	0	0	0	127
CHLAMYDIAL INFECTIONS	283	26	19	27	22	18	0	0	0	0	0	0	0	112
GONORRHEA	31	3	2	4	4	1	0	0	0	0	0	0	0	14
LYMPHOGRANULOMA VENEREUM	0	0	0	0	0	0	0	0	0	0	0	0	0	0
SYPHILIS, INFECTIOUS	5	0	0	0	0	1	0	0	0	0	0	0	0	1
INVASIVE DISEASES, NOT VACCINE PREV.	14	1	1	0	0	0	0	0	0	0	0	0	0	2
STREPT GROUP A	7	0	0	0	0	0	0	0	0	0	0	0	0	0
STREPT GROUP B	7	1	1	0	0	0	0	0	0	0	0	0	0	2
VACCINE PREVENTABLE DISEASES	149	2	4	1	3	0	0	0	0	0	0	0	0	10
DIPHTHERIA	0	0	0	0	0	0	0	0	0	0	0	0	0	0
HAEMOPHILUS INFLUENZAE, INVASIVE	1	0	0	0	0	0	0	0	0	0	0	0	0	0
HEPATITIS A	1	0	0	0	0	0	0	0	0	0	0	0	0	0
HEPATITIS B, ACUTE	0	0	0	0	0	0	0	0	0	0	0	0	0	0
HEPATITIS B, CHRONIC	16	0	0	1	1	0	0	0	0	0	0	0	0	2
MEASLES	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MUMPS	0	0	0	0	0	0	0	0	0	0	0	0	0	0
**PERTUSSIS	122	1	2	0	0	0	0	0	0	0	0	0	0	3
RUBELLA	0	0	0	0	0	0	0	0	0	0	0	0	0	0
STREPT PNEUMO, INVASIVE	4	1	2	0	2	0	0	0	0	0	0	0	0	5
TETANUS	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MISCELLANEOUS	5	0	0	0	0	0	0	0	0	0	0	0	0	0
GRAND TOTAL OF REPORTS	773	44	36	49	47	44	0	0	0	0	0	0	0	220

*Due to high incidence, Tompkins Co. designated "sentinel county" by NYSDOH, only 20% of reported lab confirmed cases are investigated.

**Mayo lab not NYSDOH approved for pertussis, all positive PCR results = "probable" case.

6/25/13

May 2013 Summary of DC103s by Disease without Name

CAMPYLOBACTERIOSIS

DIAGNOSIS DATE	SEX	RUNNING COUNT	AGE	OTHER
5/17/2013	F	1	26	

CHLAMYDIA

DIAGNOSIS DATE	SEX	RUNNING COUNT	AGE	OTHER
5/1/2013	M	1	20	
5/2/2013	F	2	17	
5/6/2013	F	3	19	
5/8/2013	M	4	25	
5/9/2013	M	5	24	
5/12/2013	M	6	23	
5/13/2013	F	7	19	
5/16/2013	F	8	17	
5/20/2013	F	9	27	
5/20/2013	M	10	39	
5/20/2013	M	11	19	
5/20/2013	F	12	15	
5/21/2013	M	13	22	
5/24/2013	F	14	20	
5/24/2013	F	15	21	
5/24/2013	F	16	23	
5/29/2013	F	17	20	
5/30/2013	M	18	23	

CRYPTOSPORIDIOSIS

DIAGNOSIS DATE	SEX	RUNNING COUNT	AGE	OTHER
5/9/2013	M	1	39	
5/27/2013	M	2	22	

GONORRHEA

DIAGNOSIS DATE	SEX	RUNNING COUNT	AGE	OTHER
5/6/2013	M	1	19	

HEPATITIS C, CHRONIC

DIAGNOSIS DATE	SEX	RUNNING COUNT	AGE	OTHER
5/6/2013	F	1	31	
5/3/2013	M	2	64	
5/10/2013	M	3	43	
5/17/2013	M	4	54	
5/16/2013	F	5	24	
5/20/2013	F	6	24	
5/24/2013	M	7	56	
5/23/2013	M	8	37	

LYME DISEASE

DIAGNOSIS DATE	SEX	RUNNING COUNT	AGE	OTHER
5/22/2013	F	1	66	

SHIGELLOSIS

DIAGNOSIS DATE	SEX	RUNNING COUNT	AGE	OTHER
5/11/2013	F	1	33	

SYPHILIS,LATE LATENT

DIAGNOSIS DATE	SEX	RUNNING COUNT	AGE	OTHER
5/8/2013	M	1	57	

YERSINIOSIS

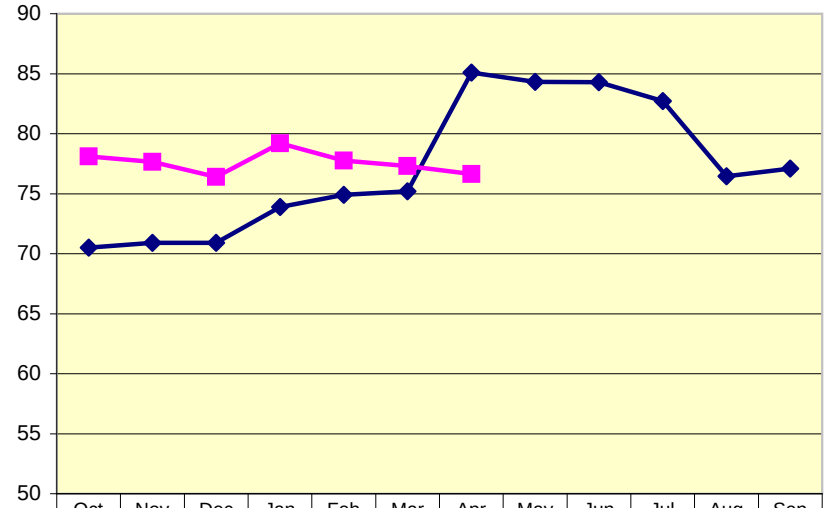
DIAGNOSIS DATE	SEX	RUNNING COUNT	AGE	OTHER
5/22/2013	F	1	85	

TOTAL DISEASE COUNT 34 *

****Total disease count does not include individuals who received rabies post-exposure vaccine.***

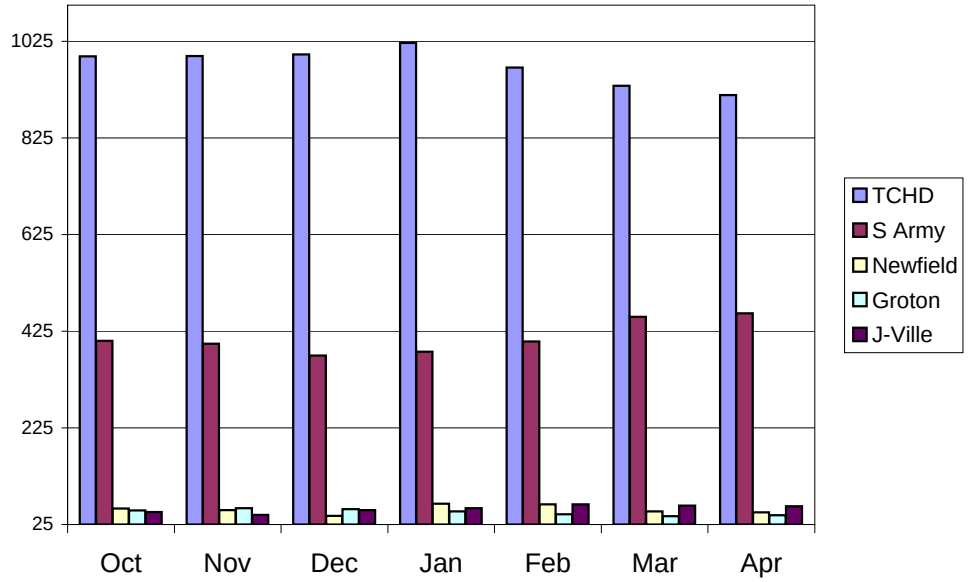
Tompkins County WIC Dashboard for July BOH Meeting - Report of official NYS WIC statistics - usually 3 month lag

Percentage of Caseload Target

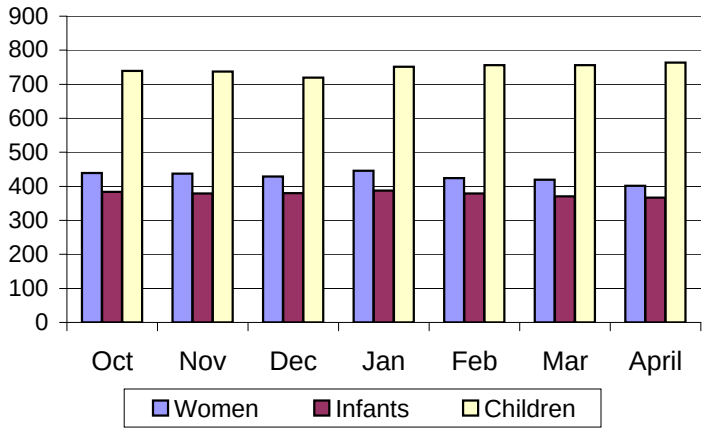


	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FFY12	70.50	70.90	70.90	73.90	74.90	75.20	85.10	84.31	84.30	82.71	76.45	77.10
FFY 13	78.10	77.65	76.40	79.20	77.75	77.30	76.65					

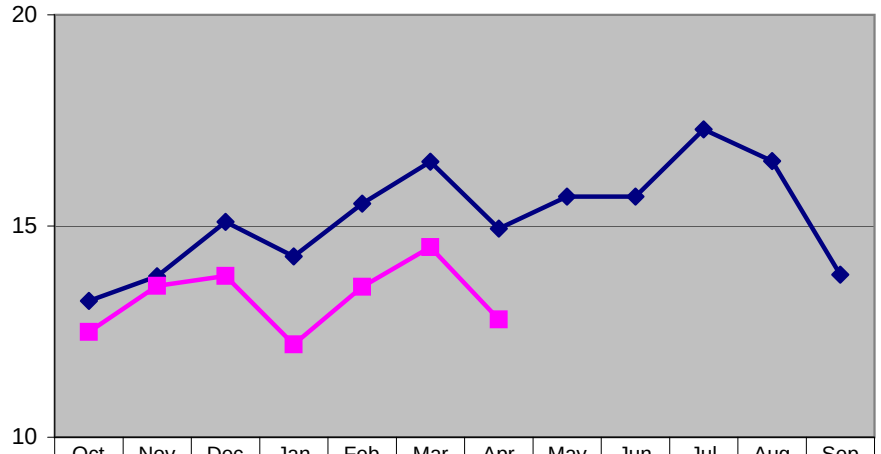
WIC Participants Receiving Benefits at each Site



Total Number of Women, Infants & Children Receiving Benefits



Participant No Show Rate



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FFY12	13.23	13.81	15.10	14.28	15.53	16.52	14.94	15.70	15.70	17.29	16.54	13.85
FFY 13	12.49	13.58	13.82	12.20	13.56	14.50	12.79					

Total WIC Participation	April 12	April 13
	1509	1533

WIC ParticipantTarget Caseload	FFY 2012	FFY 2013
	2000	2000

Children with Special Care Needs Division													
Statistical Highlights 2013													
													2013
	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Totals
Early Intervention Program													
Number of Program Referrals	38	30	30	37	35	27	0	0	0	0	0	0	197
Initial Concern/reason for referral:													
-- Birth/Medical History													
-- DSS Founded Case		1	3			2							
-- Failed MCHAT Screening													
-- Gestational Age	3	1	1	1	1	3							10
-- Global Delays				1		1							2
-- Hearing				1									1
-- Physical													0
-- Feeding		3		1	1	1							
-- Gross Motor	7	4	8	8	8	9							44
-- Gross Motor & Feeding				1	1								2
-- Gross Motor & Fine Motor				2	1								3
-- Gross Motor & Social Emotional			2		1								3
-- Fine Motor			2	1									3
-- Fine Motor/Vision													0
-- Vision													
-- Social Emotional	2	2	1	1	2								8
-- Social Emotional & Adaptive													
-- Social Emotional & Cognitive													0
-- Social Emotional & Feeding		1											
-- Social Emotional & Vision													0
-- Speech	16	12	8	7	9	8							60
-- Speech & Adaptive													0
-- Speech & Cognitive	1												1
-- Speech & Gross Motor			2	2		1							
-- Speech & Social Emotional	2	1	1	1	3								8
-- Speech & Feeding				1									1
-- Speech & Hearing		1	1										2
-- Transfer from other Municipality													
-- Adaptive						1							1
-- Adaptive/Feeding	4												4
-- Vision													0
-- Qualifying Congenital / Medical Diagnosis	2	2	1	4		1							10
-- Child Find (At Risk)	1	2		5	8								16
Total # of clients qualified and receiving svcs	181	201	203	229	235	247							
Total # of clients pending intake/qualification	39	38	39	40	28	28							
Total # qualified and pending	220	239	242	269	263	275	0	0	0	0	0	0	
Average # of Cases per Service Coordinator	55	59.75	60.5	67.25	65.75	68.75	0	0	0	0	0	0	
# of Family/Client visits													
-- Intake visits	24	27	25	16	25	24							141
-- Introduction Visits	0	0	0	0	0	0							0
-- IFSP Meetings	48	46	43	52	54	26							269

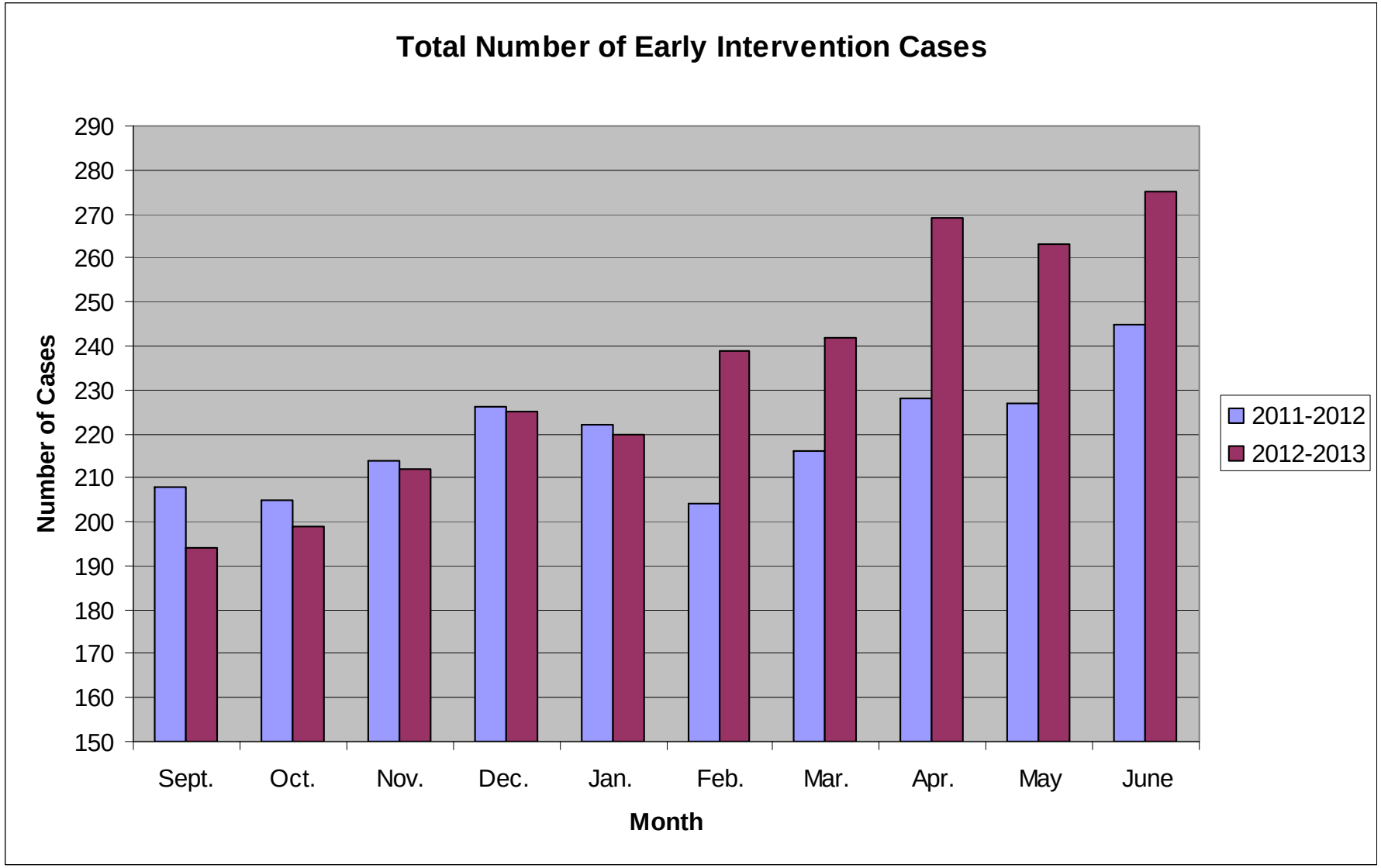
Children with Special Care Needs Division													
Statistical Highlights 2013													
													2013
	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Totals
-- Amendments	13	14	14	20	23	23							107
-- Evaluations	30	29	29	35	34	25							182
Early Intervention Program (continued)													
-- Clinic Visit	0	0	0	0	0	0							0
-- DSS Visit	0	0	1	1	1	0							
-- EIOD visits	4	0	6	10	1	0							21
-- Observation Visits	42	28	37	35	26	23							191
-- CPSE meetings	10	2	8	2	8	13							43
-- Family meetings	0	0	0	0	0	2							2
-- Program Visit	0	1	0	2	0	1							4
-- Family Training/Team Meetings	1	0	0	0	1	0							2
-- Transition meetings	22	6	10	2	6	3							49
-- Other Visits	0	0	2	0	0	3							5
# of Individualized Family Service Plans Completed	48	48	42	52	53	38							281
# of Amendments to IFSPs Completed	13	15	14	21	24	30							117
Children with Services Pending													
-- Assistive Tech	0	0	1	0	0	3							
-- Audiological	0	0	0	0	0	0							
-- Feeding	0	0	0	0	0	0							
-- Group Developmental Intervention	0	0	0	0	0	0							
-- Nutrition	1	0	0	0	0	0							
-- Occupational Therapy	1	1	0	1	5	0							
-- Physical Therapy	0	1	1	0	0	0							
-- Social Work	0	0	0	1	2	1							
-- Special Education	1	0	0	1	1	1							
-- Speech Therapy	0	0	0	0	0	0							
# of Evaluations Pending	9	4	7	11	2	0	0	0	0	0	0	0	
Type:													
-- Diagnostic Psychological													0
-- Developmental Pediatrician													0
-- Other													0
-- Supplemental Evaluations	9	4	7	11	2	0	0	0	0	0	0	0	33
Type:													
-- Audiological	1	0	3	3	1	0							8
-- Auditory Brain Response (ABR)	0	0	0	0	0	0							0
-- Feeding	0	1	1	1	0	0							3
-- Physical Management Clinic	0	0	0	0	0	0							0
-- Physical Therapy	1	0	1	1	1	0							4
-- Speech	2	2	1	2	0	0							7
-- Occupational Therapy	5	1	1	4	0	0							11
-- Vision	0	0	0	0	1	0							
# of Evaluations Completed	7	6	5	3	13	9	0	0	0	0	0	0	43
Type:													0

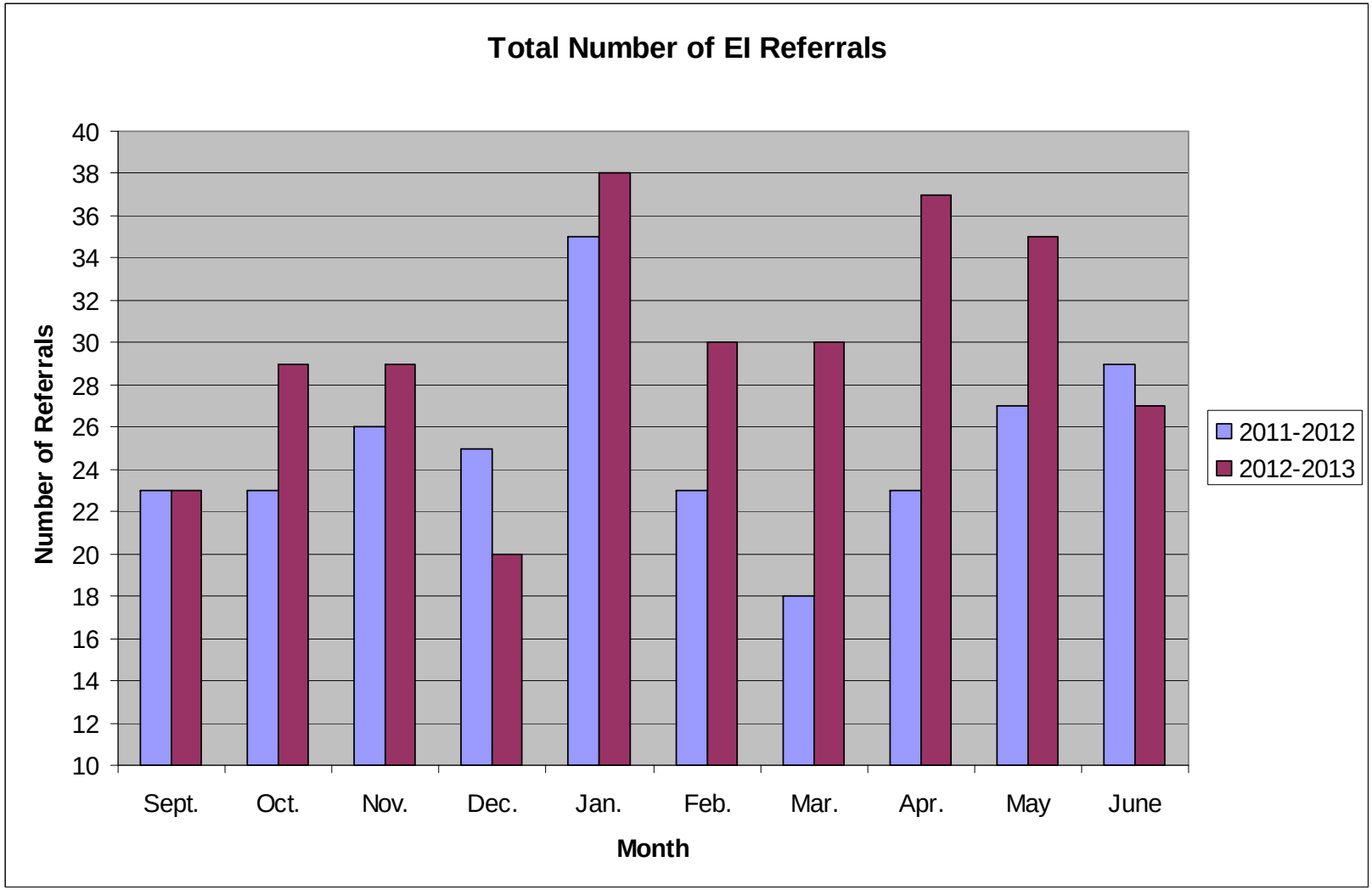
Children with Special Care Needs Division													
Statistical Highlights 2013													
													2013
	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Totals
-- Diagnostic Psychological													0
-- Developmental Pediatrician	1												1
-- Other													0
-- Supplemental Evaluations	6	6	5	3	13	9	0	0	0	0	0	0	42
Early Intervention Program (continued)													
Type:													
-- Audio	0	1	2	1	3	2							9
-- Feeding	0	0	0	0	0	0							
-- Occupational Therapy	4	4	2	1	6	2							19
-- Physical Management Clinic	0	0	0	0	0	0							0
-- Physical Therapy	1	1	0	1	1	2							6
-- Social Emotional	0	0	0	0	0	1							
-- Speech Therapy	1	0	1	0	3	2							7
-- Vision	0	0	0	0	0	0							0
Autism Spectrum													
-- Children currently diagnosed:	0	0	0	0	0	0							
-- Children currently suspect:	6	5	8	10	14	3							
Children with 'Other' Diagnosis													
-- Agenesis Corpus Collosum	0	0	0	1	1	1							
-- Cardiac Anomolies	2	1	1	3	3	4							
-- Cerebral Palsy	3	2	2	5	5	4							
-- Chromosome 22Q Deletion	1	1	1	1	1	1							
-- Cleft Lip/Palate	2	2	2	2	2	2							
-- Congenital Anomoly	0	2	2	1	1	1							
-- Cyclic Neutropenia	0	1	1	1	1	1							
-- Down Syndrome	1	1	1	2	2	1							
-- Gastroesophageal reflux disease (GERD)	0	1	1	0	0	0							
-- Hearing Impairment	0	0	0	1	1	1							
-- Hydrocephalus	2	2	2	3	3	3							
-- Hypotonia -- Severe	1	1	1	1	1	1							
-- Laryngomalacia	1	1	1	1	1	1							
-- Metabolic Disorder	0	1	1	1	1	1							
-- Microtia Atresia	1	1	1	1	1	0							
-- Musculoskeletal Anomoly	1	1	1	1	1	1							
-- Nasal Encephalocele	1	1	1	1	1	1							
-- Neurofibromatosis Type 1	2	2	2	2	2	2							
-- Prematurity	8	7	7	8	14	15							
-- Prematurity (Micro)	6	4	4	7	4	9							
-- Spina Bifida	1	1	1	1	1	1							
-- Tay Sachs Disease	1	1	1	0	0	0							
-- Temporal & Frontal Subdural Hematomas	0	0	0	1	0	0							
-- Torticollis	6	5	5	7	8	8							
-- Transposition	1	0	0	0	0	0							
-- Type 1 Diabetes	0	1	1	1	1	1							
-- Ventriculomegaly	1	1	1	1	0	1							

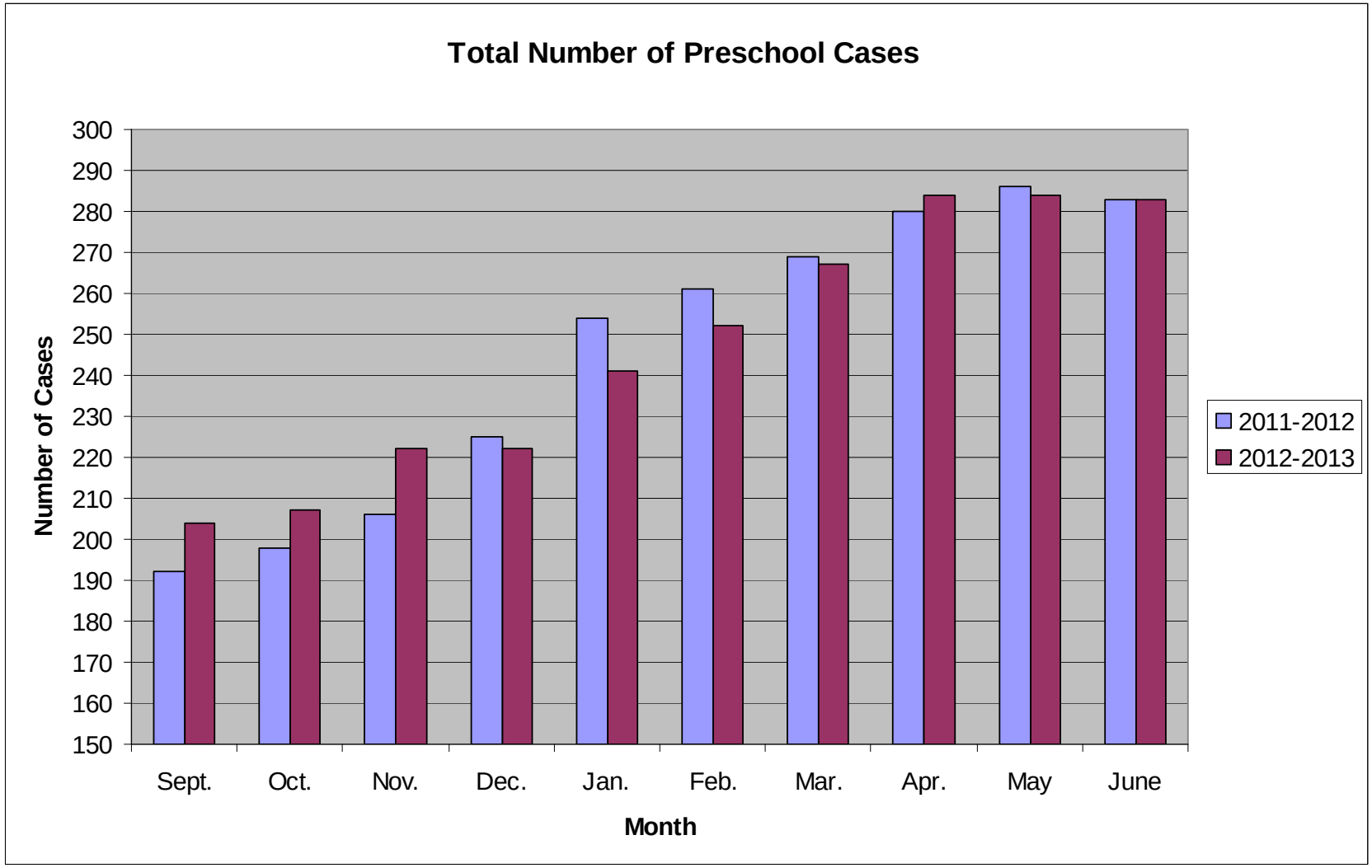
Children with Special Care Needs Division													
Statistical Highlights 2013													
													2013
	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Totals
Early Intervention Program (continued)													
Children Discharged from Early Intervention	21	10	23	9	24	25	0	0	0	0	0	0	112
-- To CPSE	10	1	1	0	0	12							24
-- Aged out	0	0	0	0	3	0							3
-- Declined	1	1	2	2	2	2							
-- Skilled out	6	3	4	1	4	0							18
-- Moved	2	1	0	1	4	4							12
-- Not Eligible	2	4	15	4	11	7							43
-- Other	0	0	1	1	0	0							2
Child Find													
Total # of Referrals	2	2	2	6	9	1							22
Total # of Children in Child Find	27	26	28	21	30	26							
Initial Consents Sent	0	8	1	4	3	0							
Initial Consents Resent	0	0	0	1	0	0							
Consents Returned	0	4	1	0	2	2							
ASQs Sent	8	13	7	9	9	2							
ASQs Returned	0	5	12	5	4	2							
MD Letters sent with ASQ Results	8	4	0	0	3	2							
Total # Transferred to Early Intervention	0	0	1	2	0	1							4
Total # of Discharges	0	0	1	12	4	5							22
Preschool Special Education													
Total # of clients qualified and receiving svcs	241	252	267	284	284	283	0	0	0	0	0	0	
Children per School District													
-- Ithaca	132	139	142	148	143	142							
-- Dryden	37	37	43	47	55	58							
-- Lansing	21	24	25	27	27	25							
-- Newfield	29	29	33	34	32	30							
-- Groton	11	12	14	16	15	15							
-- Trumansburg	11	11	10	11	11	12							
-- Spencer VanEtten	0	0	0	0	0	0							
-- Newark Valley	0	0	0	0	0	0							
-- Odessa-Montour	0	0	0	0	0	0							

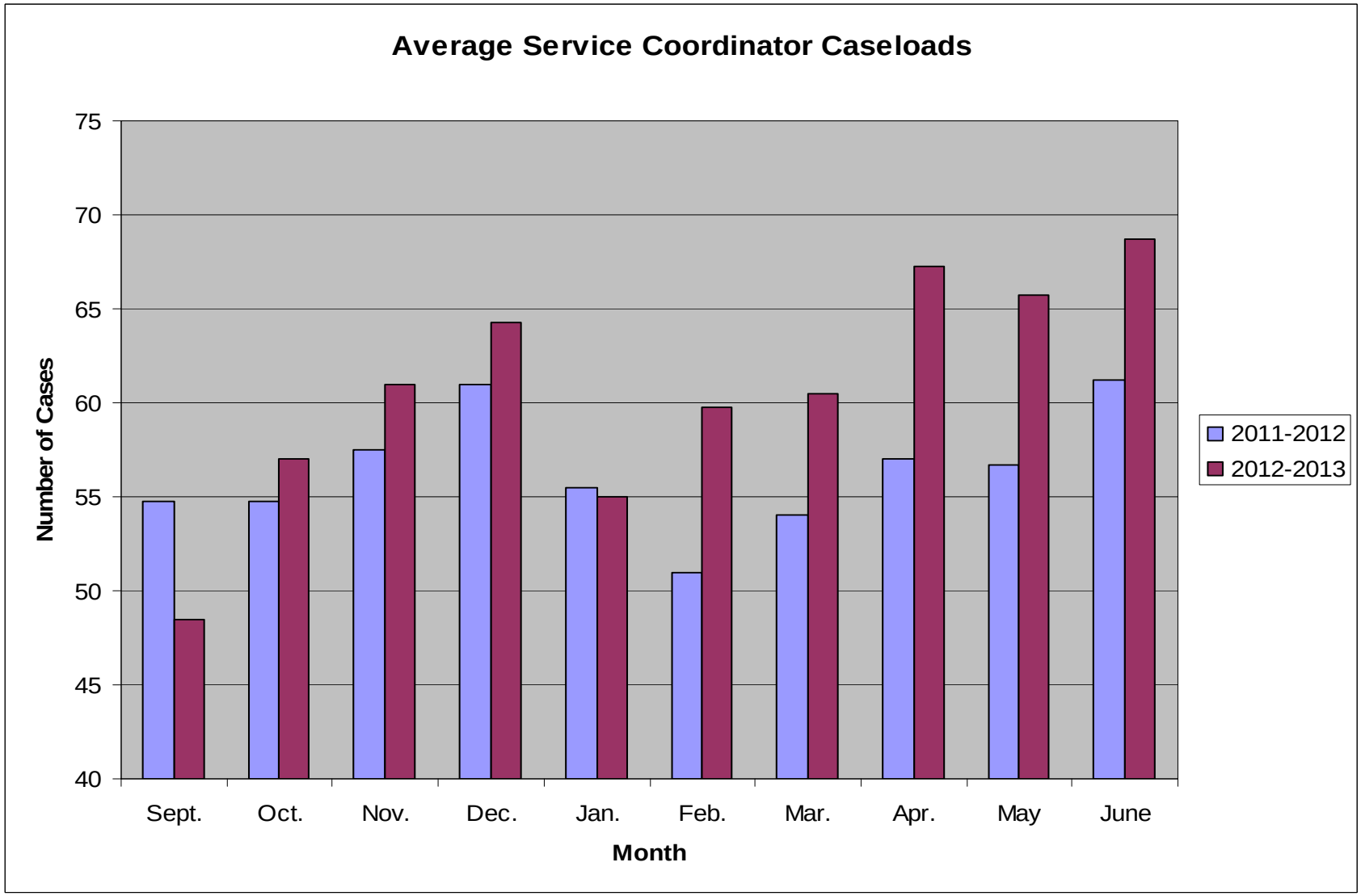
Children with Special Care Needs Division													
Statistical Highlights 2013													
													2013
	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Totals
-- Candor	0	0	0	1	1	1							
-- Moravia	0	0	0	0	0	0							
-- Cortland	0	0	0	0	0	0							
Breakdown of services received													
-- Speech Therapy (individual)	131	136	146	161	163	157							
-- Speech Therapy (group)	7	12	12	12	9	7							
-- Occupational Therapy (individual)	34	38	41	48	50	50							
-- Occupational Therapy (group)	3	3	2	1	2	2							
Preschool Special Education (continued)													
-- Physical Therapy (individual)	21	22	24	26	25	24							
-- Physical Therapy (group)	1	0	1	1	1	1							
-- Transportation													
-- Birnie Bus	32	35	36	35	35	38							
-- Ithaca City School District	29	34	34	33	33	30							
-- Parent	1	1	1	2	2	2							
-- Birnie Bus/Parent	0	0	0	0	0	0							
-- Service Coordination	16	17	20	19	18	16							
-- Counseling	35	38	44	51	48	50							
-- 1:1 (Tuition Program) Aide	0	4	5	6	6	5							
-- Special Education Itinerate Teacher	25	29	32	36	36	36							
-- Parent Counseling	8	7	8	11	10	10							
-- Program Aide	0	0	0	0	0	1							
-- Teaching Assistant	7	7	7	7	7	8							
-- Psychological Services	0	0	0	0	0	0							
-- ASL Interpreter	0	0	0	0	0	0							
-- Audiological Services	0	0	0	0	0	2							
-- Teacher of the Deaf	0	0	0	0	0	0							
-- Auditory Verbal Therapy	0	0	0	0	0	0							
-- Teacher of the Visually Impaired	0	1	1	1	1	1							
-- Nutrition	3	3	3	3	3	3							
-- Assistive Technology Services	1	1	0	0	0	0							
Total # of children rcvg. home based related svcs.	169	177	191	210	208	209							
Total # attending Special Ed Integrated Tuition Progr.	72	75	76	74	76	74							
-- # attending Franziska Racker Centers	44	46	47	45	48	46							
-- # attending Ithaca City School District	28	29	29	29	28	28							
Children from each school district													
(attending tuition based programs)													
-- Ithaca	37	38	38	38	36	35							
-- Dryden	12	11	12	10	13	13							
-- Lansing	3	4	4	3	3	3							
-- Groton	5	6	6	6	6	6							

Children with Special Care Needs Division													
Statistical Highlights 2013													
													2013
	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Totals
-- Newfield	12	13	13	13	14	13							
-- Trumansburg	3	3	3	4	4	4							
-- Odessa-Montour	0	0	0	0	0	0							
-- Spencer VanEtten	0	0	0	0	0	0							
-- Moravia	0	0	0	0	0	0							
Municipal Representation													
Committee on Preschool Special Education													
-- Ithaca	30	23	28	28	32	26							
-- Dryden	13	8	4	14	20	11							
-- Groton	0	0	0	0	5	0							
-- Lansing	1	1	2	1	8	12							
-- Newfield	1	4	1	16	13	2							
--Trumansburg	0	0	1	1	2	0							


Total Number of Early Intervention Cases
Number of Cases
290
280
270
260
250
240
230
220
210
200
190
180
170
160
150
Sept.
Oct.
Nov.
Dec.
Jan.
Feb.
Mar.
Apr.
May
June
Month
2011-2012
2012-2013


Total Number of EI Referrals
Number of Referrals
40
38
36
34
32
30
28
26
24
22
20
18
16
14
12
10
Sept.
Oct.
Nov.
Dec.
Jan.
Feb.
Mar.
Apr.
May
June
Month
2011-2012
2012-2013


Total Number of Preschool Cases
Number of Cases
300
290
280
270
260
250
240
230
220
210
200
190
180
170
160
150
Sept.
Oct.
Nov.
Dec.
Jan.
Feb.
Mar.
Apr.
May
June
Month
2011-2012
2012-2013


Average Service Coordinator Caseloads
75
70
65
60
55
50
45
40
Number of Cases
Sept.
Oct.
Nov.
Dec.
Jan.
Feb.
Mar.
Apr.
May
June
Month
2011-2012
2012-2013

TOMPKINS COUNTY HEALTH DEPARTMENT
Your Partner for a Healthy Community

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ENVIRONMENTAL HEALTH HIGHLIGHTS
June 2013

Outreach and Division News

We would like to thank Carol Chase, Senior Public Health Sanitarian and Director of the Food Protection Program, who retired on June 3, for her 25 years of service.

Carol managed the Program as she did all her work in the Division – balancing Public Health with program needs and code requirements, always with thoroughness and solid communication skills. She would jump right into new initiatives and often have them completed before the state guidance was received from Albany**.**

She took this responsibility at a time when the State was modernizing their inspection focus and methods. It was also a time when both the State and the County were becoming more reliant on computers and electronic data management. She rose to the challenges and as a result our food program became one of the most respected in the state despite being chronically understaffed.

Along the way she developed dozens of educational handouts and a comprehensive food safety manual to increase the knowledge of food safety in the restaurant community and in residents' homes.

She performed hundreds of evening and weekend inspections at the Farmers Market, festivals, and community events in her efforts to protect the public health.

Carol will be greatly missed by all of us in Environmental Health and throughout the Health Department. We all wish her health and well being in her retirement.

Hydrilla – Year 3 continues: Anne Wildman participated in the June meetings of the local and state Hydrilla Task Force. The endothall permit has been issued and the Fluridone permit application has been submitted. Because the endothall treatment is most effective when there is significant plant growth, the treatment has been delayed until at least July 8th, with the Fluridone treatment scheduled to begin approximately two weeks later. Shoreline property owners and tenants have been notified by US mail and 24-hour advance notification will be carried by local media. Water quality sampling will occur throughout the treatment period and analytical results will be posted on the EH Web page.

WHCU Interview – On June 13, Lee Rayburn from WCHU interviewed Anne Wildman. Anne discussed food safety at local festivals and fund-raising events, including the role of the Health Department and why food vendors need a permit, and providing practical food safety tips for everyone.

EH/ITS Permit Management Software Project: The contracts with Accela for software and professional services were finalized in June. Project kick-off is anticipated for mid- to late-July.

Cayuga Lake Modeling Project – Liz Cameron attended a public meeting hosted by the New York State Department of Environmental Conservation (NYSDEC) discussing the Cayuga Lake Modeling Project on the evening of June 13. Since 2002, the southern basin of Cayuga Lake has been on state and federal lists of impaired waters requiring a Total Maximum Daily Load (TMDL). The NYSDEC and Cornell University have agreed to conduct a detailed study of the sources and fate of phosphorus in Cayuga Lake as one of several conditions placed on the Cornell University Lake Source Cooling (LSC) discharge permit renewal. Once completed, the model will enable NYSDEC to establish a TMDL based on how much phosphorus can be added to the southern basin of Cayuga Lake

from all sources, while protecting the lake's water quality and aquatic habitat. The project is in the data collection phase this year.

Rabies Control Program

There were no animals confirmed rabid in Tompkins County during June. Rabies continues to be found in the wildlife population in New York with the primary carriers being raccoons, skunks, foxes, and bats. The Health Department advises avoiding contact with these animals, reporting any exposures, and keeping pet vaccinations up to date.

This is the time of year when encounters with bats increase. While only one to five percent of bats tested by the New York Wadsworth Laboratory prove to be rabid, the possibility of an undetected bite makes these encounters potentially problematic. In cases where a bat is found in a room with a sleeping person, a person with a sensory impairment, or in the presence of a child, the bat should be captured and brought to the Health Department for rabies testing. All bats that bite a person should be tested. Keep in mind the bat's brain must be intact in order to be tested.

Key Data Overview		
	This Month	**YTD**
Bites[1]	22	109
Non Bites[2]	10	25
Referrals to Other Counties	3	24
Submissions to the NYS Rabies Lab	21	67
Human Post-Exposure Treatments	11	31
Unvaccinated Pets 6-Month Quarantined[3]	0	3
Unvaccinated Pets Destroyed[4]	0	0
Rabid Animals (Laboratory Confirmed)	0	3

[1]"Bites" include all reported bites inflicted by mammals and any other wounds received while saliva is present.
[2]"Non-bites" include human exposures to saliva of potentially rabid animals. This also includes bats in rooms with sleeping people or young children where the bat was unavailable for testing.
[3]When an otherwise healthy, unvaccinated pet has contact with a rabid animal, or suspect rabid animal, that pet must be quarantined for 6 months or euthanized. Quarantine must occur in a TCHD-approved facility (such as a kennel) at the owner's expense. If the pet is still healthy at the end of 6 months, the exposure did not result in rabies and the pet is released.
[4] Pets must be euthanized if they are unvaccinated and have been in contact with a rabid or suspect rabid animal and begin to display signs consistent with rabies. Alternatively, a pet is euthanized if a prescribed 6-month quarantine cannot be performed or the owners elect euthanasia instead of quarantine.

Reports by Animal Type								
	Bites		**Animals sent to the NYS Rabies Laboratory**				**Rabid Animals**	
	Month	**YTD**	**By TCHD**	**By NYS Vet College**	**Totals**		**Month**	**YTD**
					Month	**YTD**		
Cat	10	36	0	0	0	7	0	0
Dog	11	67	0	0	0	4	0	0
Cattle	0	0	0	0	0	1	0	0
Horse/Mule	0	0	0	0	0	0	0	0
Sheep/Goat	0	0	0	0	0	0	0	0
Other Domestic	0	1	0	0	0	0	0	0
Raccoon	0	0	0	0	0	2	0	1
Bats	0	0	9	1	10	28	0	3
Skunks	0	0	0	0	0	0	0	0
Foxes	0	1	0	0	0	4	0	0
Other Wild	1	4	1	10	11	21	0	0
Totals	**22**	**109**	**10**	**11**	**21**	**67**	**0**	**3**

Childhood Lead Program

	This Month	YTD
A: Active Cases (total referrals):	0	0
A1: # of Children w/ BLL>19.9ug/dl	0	1
A2: # of Children w/ BLL 10-19.9ug/dl	2	2
B: Total Environmental Inspections:		
B1: Due to A1	2	4
B2: Due to A2	0	0
C: Hazards Found:		
C1: Due to B1	1	3
C2: Due to B2	0	0
D: Abatements Completed:	0	0
E: Environmental Lead Assessment Sent:	1	2
F: Interim Controls Completed:	0	0
G: Complaints/Service Requests (w/o medical referral):	8	27
H: Samples Collected for Lab Analysis:		
- Paint	0	0
- Drinking Water	0	1
- Soil	1	2
- XRF	1	2
- Dust Wipes	1	2
- Other	0	0

Food Program

Routine facility inspections *are conducted to protect public health. The inspections are made without advance notice to ensure that food processes are adequate, safe, and meet code requirements. It is important to keep in mind that inspections are only a "snapshot" in the entire year of a facility's operation and they are not always reflective of the day-to-day operations and overall condition of the operation*.

The following inspections were conducted with no critical violation(s) noted:

Antlers Restaurant, T-Dryden
Autumn's Ice Cream, T-Caroline
Biz & Benny's Juice Company, catering
Blue Moon Events & Catering Mobiles
Carriage House Café, C-Ithaca
Cass Park Concessions, C-Ithaca
Cayuga Lake Cruises, C-Ithaca
Cedar View Golf Course, T-Lansing
Ciao!, V-Lansing
Country Club of Ithaca Snack Bar, T-Ithaca
Dennis' Homemade Ice Cream, T-Newfield
Dryden Queen Diner, V-Dryden
The Frosty Cow, T-Dryden
Greenstar Market Events, C-Ithaca
Groton Golf & Recreation, T-Groton
Ice Cream Caboose, V-Groton
Ithaca Yacht Club, T-Ulysses
Just a Taste, C-Ithaca
Just Desserts, T-Ithaca
Kendra's Culinary Creations, T-Lansing
Lakebreeze Ice Cream, T-Lansing
Lakewatch Inn, T-Lansing
Linda's Corner Diner, T-Lansing
Little Thai House, C-Ithaca
Longview, T-Ithaca
Lou's BBQ, catering
Mercato Bar & Restaurant, C-Ithaca
Moosewood Restaurant, C-Ithaca
Mystic Water Kava Bar & Yoga Studio, C-Ithaca
On a Roll Commissary, T-Dryden
On the Street, C-Ithaca
Outdoor Store, C-Ithaca
Pickeled Orchid, mobile
Roman Village, T-Groton
Ron Don's Village Pub, V-Trumansburg
Sal's Pizzeria, C-Ithaca
Save the Animals Go Vegan Bistro, catering
Simeon's on the Commons, C-Ithaca
Sri Lankan Curry in a Hurry, C-Ithaca
Sunrise Samosas, V-Freeville
Stella's Barn Restaurant and Gifts, T-Newfield
Taughannock Farms Inn, T-Ulysses

Thai Palace, catering
Tucker's Catering, C-Ithaca
Vanilla Rain Cupcakes, catering
Victory Lane Delights, V-Dryden
Waterwheel Café, V-Freeville
William Henry Miller Inn, C-Ithaca
Word of Mouth Catering, V-Trumansburg
ZaZa's Cucina, C-Ithaca

The Hazard Analysis Critical Control Point (HACCP) Inspection is an opportunity for the establishment to have the health department review food processes in the facility to make sure that all potential hazards are identified and to assure that the best food safety practices are being used.

HACCP Inspections were conducted at the following establishments: None

Re-Inspections *are conducted at any establishments that had a critical violation(s) to ensure that inadequate or unsafe processes in a facility have been corrected.*

The following re-inspections were conducted with no violations noted:

Blue Moon Events & Catering, mobile
Clubhouse Grille, V-Trumansburg
The Connection/Loco, C-Ithaca
Country Club of Ithaca, T-Ithaca
Futai Buffet, C-Ithaca
Holiday Inn – Max's, C-Ithaca
Inlet Island Café, C-Ithaca
Mexeo, C-Ithaca
Sadya South Indian, catering
Saigon Kitchen, C-Ithaca
Toad's Too, V-Freeville
Tokyo Hibachi, Sushi and Asian Bistro, C-Ithaca

Critical violations *may involve one or more of the following: the condition of food (e.g. food that may be at improper temperatures on delivery or damaged by rodents), improper food cooking and storage temperatures (e.g. food cooked to and/or held at improper temperatures), improper food preparation practices (e.g. preparing ready-to-eat foods with bare hands), and water and/or sewage issues (e.g. low disinfection levels in the water system). These critical violations relate directly to factors that could lead to food related illness.*

Critical Violations were found at the following establishments:

Inlet Island Café, C-Ithaca

Toxic chemicals were stored so that contamination could occur. The storage was re-arranged during inspection.

Potentially hazardous foods were not prepared from pre-chilled ingredients. The products were rapidly chilled to 45°F or below prior to return to service.

Toad's Too, V-Freeville

Cooked or prepared foods were subject to cross-contamination. The storage was re-arranged during inspection.

Blue Moon Events & Catering, Throughout Tompkins

Enough hot holding equipment was not operated to keep potentially hazardous foods above 140°F. Products were rapidly reheated to 165°F or above before return to service.

Enough refrigerated storage equipment was not maintained so that all potentially hazardous foods were stored at 45°F or below. Products were rapidly chilled to 45°F or below and the refrigeration unit was adjusted.

Plum Tree Restaurant, C-Ithaca

Food workers did not use proper utensils or gloves to eliminate bare hand contact with ready to eat foods. The product was discarded during inspection.

Enough refrigerated storage equipment was not maintained so that all potentially hazardous foods were stored at 45°F or below. Products were observed at 48-50°F. Products were moved to a functioning cooler to be chilled to 45°F or below before use.

Taste of Thai Express, C-Ithaca

Potentially hazardous foods were not kept at or below 45°F during cold holding. Products were observed in two separate locations at 52°F and 57°F in cold holding. Products were removed from service and placed in walk-in to be cooled to 45°F or below.

Potentially hazardous foods were not kept at or above 140°F during hot holding. Rice stored in a rice warmer was observed at 115°F. The product was discarded during the inspection.

A-1 Pizzeria and Restaurant, T-Dryden

Enough refrigerated storage equipment was not maintained so that potentially hazardous foods were kept at 45°F or below during cold holding. Products were observed at 50-54°F in the cooler. Products were discarded during the inspection.

Ithaca Zen Center, T-Danby

Cooked or prepared foods were subject to cross-contamination from raw foods. The storage was re-arranged during the inspection.

Applebee's Neighborhood Bar & Grill, V-Lansing

Enough refrigerated storage equipment was not maintained so that potentially hazardous foods were kept at 45°F or below during cold holding. Products were observed at 50-51°F in two cooling units. Products were removed from service and placed in the walk-in to be cooled to 45°F or below.

Sammy's Pizzeria and Restaurant, C-Ithaca

Potentially hazardous foods were not kept at or below 45°F during cold holding. Products were observed in reach-in cooler at 55-57°F. Products were discarded during the inspection.

Potentially hazardous foods were not stored under refrigeration. Observed pizza on display at 78°F with no temperature logs filled out. The facility was not in compliance with their waiver.

Mahogany Grill, C-Ithaca

Enough refrigerated storage equipment was not maintained so that potentially hazardous foods were kept at 45°F or below during cold holding. Products were observed at 50-60°F in cooler. Products were discarded at inspection.

Vietnam Hai Hong, C-Ithaca

Potentially hazardous foods were not stored under refrigeration. Bean sprouts were observed at 70°F on a food preparation counter. The product was discarded during the inspection.

Rogues Harbor Steak & Ale, T-Lansing

Enough refrigerated storage equipment was not maintained so that potentially hazardous foods were kept at 45°F or below during cold holding. Products were observed at 50-56°F in two coolers. Products were discarded during the inspection.

Ling Ling Garden, T-Ithaca

Toxic chemicals were stored so that contamination could occur. The storage was re-arranged during inspection.

Sadya South Indian, Throughout Tompkins

Potentially hazardous foods were not kept at or below 45°F during cold holding. Products were observed in cooler at 53°F. Products were removed from service and chilled to 45°F before use.

KoKo, C-Ithaca

Enough refrigerated storage equipment was not maintained so that potentially hazardous foods were kept at 45°F or below during cold holding. Products were observed at 50-56°F in a cooler. Products were removed from service and placed in alternate coolers to be cooled to 45°F or below.

Temporary Food Service Operation Permits *are issued for single events at one location. The Food Protection Program* ***issued 32 temporary permits****.*

Temporary food operation inspections *are conducted to protect public health. The inspections are made without advance notice to ensure that the food processes at the event are adequate, safe, and meet code requirements. The operation must correct Critical Violations during the inspection. When a Temporary Food Operation has Critical Violation/s, a re-inspection is conducted when the event is longer than one day.*

The following inspections were conducted with no violation(s) noted:

B & B Kettle Korn, C-Ithaca
Cayuga Medical Center, T-Ithaca
Dryden Grange, V-Dryden
Dryden Republicans, V-Dryden
Dryden Rotary Club, V-Dryden
Dryden United Methodist Church, V-Dryden
East Hill Flying Club, Inc, V-Lansing
Greenstar Market, C-Ithaca
Ithaca Beer Company, T-Ithaca
K & R Catering, T-Dryden
Kiwanis Club of Dryden, V-Dryden
Leon's Soul Food, C-Ithaca
Nicole Lotito-Blodgett, V-Dryden
PDR's Catering, C-Ithaca
Queen of Tarts, C-Ithaca
Sweet Dreams Concessions, C-Ithaca
Travelers Kitchen, LLC, C-Ithaca

Critical Violations were found at the following establishments:

Greenlife Nutrition Center, C-Ithaca

Potentially hazardous foods were not kept at or below 45°F during cold holding. Products were observed in a cooler at 53°F. Products were removed from service and chilled to 45°F before use.

West Indies Pot, C-Ithaca

Potentially hazardous foods were at improper temperatures. Cooked chicken was observed at 131°F. The product was removed from service and rapidly reheated to above 165°F before being returned to service.

Pre-Operational inspections *are conducted, following a thorough review of proposed plans, at new or extensively remodeled facilities to ensure code compliance prior to opening to the public.*

The following pre-operational inspections were conducted:
Blue Moon Catering Kitchen, C-Ithaca
Coal Yard Café, T-Ithaca
CU - Conference Catering Kitchen, T-Ithaca

Plans Approved:
CU – Conference Catering Kitchen, T-Ithaca

New Permits Issued:
Blue Moon Catering Kitchen, C-Ithaca
Coal Yard Café, T-Ithaca
CU – Conference Catering Kitchen, T-Ithaca
CU – Café Jennie, C-Ithaca
CU – Dairy Bar, T-Ithaca
Cultural Blend, catering
D&D Barbecue, catering
Greenstar Market Events, C-Ithaca
Little Ceasars, C-Ithaca
Ollie's Ice Cream, mobile
The Pickeled Orchid, catering
West Indies Flavor, catering

The Food Protection Program ***received and investigated four complaints*** *related to issues and/or problems at permitted food service establishments.*

Engineering Plans Approved

- Guidi Cabins, Phase I, II, III, 1 - 600 gpd sewage system, 2 - 720 gpd sewage systems, Newfield-T
- Autumn Ridge Subdivision, Lot 5 Redesign, 440 gpd sewage system, Lansing-T
- Ward Development, 660 gpd sewage system, Newfield-T

Two plans for cross-connection control devices to protect municipal water systems from hazardous connections were approved this month.

Problem Alerts/Emergency Responses

There were no Boil Water Orders (BWOs) or other emergencies reported this month.

BWOs remain in effect at:

- 12-01-8 J-A-M Mobile Home Park, T-Lansing. BWO issued 8/16/12 due to positive total coliform results. Lost disinfection waiver. Enforcement initiated due to failure to provide disinfection or to connect to municipal water.

Healthy Neighborhoods Program

On June 3, Pat Jebbett and Eric Shearer met with a Child Development Council's staff member and discussed the Healthy Neighborhoods Program with her. We also provided her with HNP information for the clients that the CDC program serves.

On June 8, Pat Jebbett and Anne Wildman participated in Healthy Neighborhoods Program outreach at the GIAC Festival. Seven people signed up for home visits and at least 25 more people took information with them and asked questions about the program.

HNP staff and CSCN staff have been communicating back and forth about the functions of each other's programs. A meeting will be held to discuss more specifics about each program and to determine how best to share information.

	This Month	YTD
# Home Visits	17	269
# Revisits	2	71
# Asthma Homes	3	40
# Homes Approached	100	508
Products Distributed:		
Carbon Monoxide Detectors	8	148
Smoke Detectors	6	143
Fire Extinguishers	14	235
Surge Protectors	0	16
Radon Test Kits	1	49
Batteries for SD/CO	7	176
HEPA Vacuums	0	2
Vinegar	15	162
Baking Soda	15	295
Spray Bottles	13	230
Brushes	14	237
Mops	0	4
Buckets	0	89
Baby Gates	0	6
Safety Latches	9	67
Door Knob	1	61
Stove Knobs	2	41
Pest Control Products	2	25
Nightlights	12	119
No-Slip Bathtub Strips	15	211
Pillow Case	3	51
Flashlights	15	211

Status of Enforcement Actions

Office Conference Scheduled: JAM MHP, T-Lansing, Jack and Mary Burns, owners: water system violations, 7/15

Office Conferences Held: None

Compliance Schedules/Board of Health Orders/PH Director's Orders

- Village of Dryden, PWS: violations of Subpart 5-1 for Public Water Systems; signed a Compliance Schedule with PHD Orders on 11/15/2012; BOH ordered Compliance on 12/11/2012; **awaiting compliance.**
- Rite Aid Pharmacy #4716, C-Ithaca, Kevin McKee, manager: Adolescent Tobacco Prevention Act (ATUPA) violation signed Stipulation Agreement with PHD Orders on 4/11/2013; BOH assessed $450 penalty with mandatory $50 State surcharge on 5/14/2013; second notice sent; **awaiting payment**.
- Pete's Grocery, C-Ithaca, Mark Zaharis, owner: ATUPA violation; signed Stipulation Agreement with PHD Orders on 4/23/2013; BOH assessed $450 penalty with mandatory $50 State surcharge on 5/14/2013; **payment received, case closed**.
- Rogue's Harbor Inn, T-Lansing, Eileen Stout, owner: sewage system violation; signed Stipulation Agreement with PHD Orders on 4/4/2013; BOH assessed $400 penalty on 5/14/2013; sewage system replaced; second notice sent; **awaiting payment.**

Referred to Collection:

- CC's, C-Ithaca, Jian Wang, owner
- Blue Frog Café, V-Lansing, Karina Murphy, manager
- P & Y Convenience Store, T-Lansing, Min Gyu Park owner
- 1795 Mecklenburg Road, T-Enfield, Vincent Bruno, owner
- Blue Frog Café, V-Lansing Karina Murphy, owner
- William Crispell, owner, T-Caroline – two monetary penalties

Training

Janice Wood attended Defensive Driver training on June 13 and Liz Cameron, Brenda Coyle, and Audrey Balander attended the training on June 19.

TOMPKINS COUNTY HEALTH DEPARTMENT
Your Partner for a Healthy Community

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Division for Community Health
AGENDA

Tompkins County Board of Health
July 9, 2013

Approval for:
Licensed Home Care Services Agency (LHCSA) policy and procedure revisions (attached):

- **Admission, Plan of Care and Discharge for Maternal-Child and MOMS Clients** – The policy outlines client eligibility, assessment and plan of care criteria and discharge procedures. Policy also includes new NYSDOH 5/15/13 regulations, nurses are to assess whether there is a need for palliative care and to include a plan of care for any identified needs.

- **Client Services** – Policy outlines requirements for: development, review and approval of written policies and procedures; documentation in clinical records; employee identification, and infection control for medical supplies and equipment.

- **Medical Orders** – Policy defines who may medically authorize orders and gives program specific timelines for medical orders to be reviewed and updated as needed.

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Division for Community Health

Admission, Plan of Care and Discharge For Maternal-Child, MOMS Clients

Policy & Procedures

Policy

1. Client eligibility for maternal-child or Medicaid Obstetrical Maternal Services (MOMS) services will be based on program specific criteria.
2. No client will be denied service based on the inability to pay.
3. To be eligible for services the client must be a Tompkins County resident except as approved by program guidelines or by waiver from the Public Health Director, Director of Patient Services or Community Health Services Supervisor.
4. Home based services are provided in a safe environment for the client and staff.
5. The Community Health Nurse Supervisor is an RN position responsible for direct clinical supervision of the Community Health Nurses providing care services.

Admission Procedure

1. Community Health Services (CHS) intake nurse assesses referrals and client requests for services based on:
   - Scope of services available,
   - Sufficient staffing,
   - Client eligibility, and that the
   - Client needs can safely and adequately be met in the clinic and home environment.
2. Upon admission, the CHS Community Health Nurse (CHN) will assess the client's needs. Assessment includes the following policies found in the MOMS Policy Manual:
   - Risk Assessment
   - Nutritional Assessment
   - Psychosocial Assessment
3. Based on their professional assessment nurses then develop a plan of care and goals as defined by program specific guidelines or requirements.

Plan of Care Procedure

1. The Plan of Care includes the following information:
   - Pertinent diagnoses,
   - Probable course of the client's condition and/or illness,
   - Need for palliative care,
   - Psychosocial assessment,
   - Frequency of anticipated nursing visits,
   - Medications and treatments, if any
   - Nutritional assessment, and
   - Any functional limitations.
2. The Plan of Care is reviewed and revised as frequently as necessary to reflect the changing care needs of the client, but no less frequently than every six (6) months.

3. The nurse documents the Plan of Care reviews in the clinical record, and
4. The nurse promptly alerts the client's authorized medical practitioner and any other providers to any significant changes in the client's condition that indicate a need to alter the Plan of Care.

Discharge Procedure

1. A discharge plan is initiated prior to agency discharge of the client in order to assure a timely, safe and appropriate transition for the client.
2. Clients are discharged from services when mutually agreed to goals are accomplished or when the client declines continued care, moves, or is unreachable or other circumstances prevent goal achievement and or further care.
3. If a client needs to be discharged from services for reasons of safety, or services will no longer fit program guidelines the nurse will discuss and review the case with the Community Health Nurse (CHN) Supervisor or Team Leader.
4. Alternative options for care or service will be explored based on community resources. If alternate care is found and acceptable to the client the nurse will refer or transfer care as appropriate.
5. If the decision is to discharge, the nurse will notify the authorized medical practitioner and consult with the client and any other professional staff involved in coordinating the plan of care, no less than 48 hours prior to discharge.
6. The CHN Supervisor will assure problematic cases are summarized for presentation and review by the Community Health Quality Advisory Committee.

References

- Title 10 Health NYCRR section 766.2-Patient Service Policies and Procedures (11/1/95) and 766.3 Plan of Care ~~(11/1/95~~5/15/13)
- MOMS Policy Manual, Section II

Original: 6/28/12
Revised: 9/25/12, 5/24/13
NYSDOH Licensed Home Care Services Agency Approval: 11/14/12

Community Health Quality Assurance Committee: ~~pending~~ 6/18/13
Board of Health Approval: *pending7/9/13*

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Division for Community Health

Client Services

Policies & Procedures

Policy

The Tompkins County Health Department (TCHD) Division for Community Health (Division) Director of Patient Services (DPS) will ensure that:

1. Written policies and procedures consistent with current professional standards of practice are developed and implemented for each service provided by the Division; these services currently include: registered professional nursing (refer to MOMS Policy Manual section II) and the use of medical supplies, equipment and appliances in the provision of care (refer to MOMS Policy Manual, section III);
2. Policies and procedures are reviewed annually and revised as necessary;
3. The delivery of service is documented in the clinical record; and to the extent possible, provided by the same personnel to the same client;
4. Persons providing care in the home display current TCHD picture identification including name, job title and name of agency. TCHD ID is returned to TCHD upon termination of employment;
5. Policies and procedures for the storage, cleaning and disinfection of medical supplies, equipment and appliances are established and that the nursing staff evaluate the appropriateness, cleanliness and safety of equipment prior to and after use (see MOMS Policy Manual, Section III);
6. Any nursing service (procedure or treatment) not previously provided in the clinic or home will be:
   a. Reviewed by the DPS in consultation with the TCHD Medical Director regarding safety and appropriateness of the service, and
   b. Reviewed by the Community Health Quality Assurance (CHQA) Committee prior to request for Board of Health approval.
   c. Staff will be trained as needed and appropriate for their job duties prior to provision of service.
   d. If the needs of a client require a service prior to CHQA Committee review it may be implemented with DPS and TCHD Medical Director review as noted in # 6a, and staff have been trained to provide that specific service, procedure or treatment.

References

- Title 10 Health NYCRR section 766.2 – Patient Services (11/1/95)
- MOMS Policy Manual
  - Section II, Policies on Nutrition, Antepartum and Postpartum Visits
  - Section III, Procedures for Doppler, Pregnancy Screening & Verification, Urine Testing and Universal Precautions.

Original: 8/17/12
Revised: 9/25/12
NYSDOH Licensed Home Care Services Agency Approval: 11/14/12

Community Health Quality Assurance Committee Approval: ~~*pending*~~ *6/18/13*
Board of Health Approval: *pending7/9/13*

TOMPKINS COUNTY HEALTH DEPARTMENT
Your Partner for a Healthy Community

Frank Kruppa
Public Health Director
55 Brown Road
Ithaca, NY 14850-1247

Division for Community Health

Medical Orders

Policy & Procedure

Policy

1. The Division for Community Health Services, Director of Patient Services will ensure that an order from the client's authorized practitioner is established and documented for health care services provided to clients who:
   - Are receiving services governed by the NYSDOH Licensed Home Care Services Agency regulations, NYCRR Part 766,
   - Are being actively treated by an authorized practitioner for a diagnosed health care condition, or
   - Have a health care need or change in physical status requiring medical intervention.
2. Authorized practitioner refers to a:
   - Doctor of medicine, osteopathy or podiatry, or
   - Licensed midwife, or
   - Nurse Practitioner authorized under federal and state law and applicable rules and regulations to provide medical care and services to the client (except as may be limited by third party contracts).

Procedure

1. Medical orders shall be reviewed and revised as the needs of the client indicate but no less frequently than every six (6) months except as follows:~~.~~
   - Antepartum Clients – 90 day certification
   - Postpartum Clients – 60 day certification
   - Lead, TB program clients – 90 day certification
2. Medical orders shall reference all diagnoses, medications, treatments, probable course or outcome of care, need for palliative care, and other pertinent client information relevant to the client Plan of Care.
3. Medical orders shall be authenticated by an authorized practitioner within thirty (30) days after admission to services.
4. When changes in the client's medical orders are indicated due to a change in condition, interim orders, including telephone orders, shall be authenticated by the authorized practitioner within thirty (30) days.

References

- Title 10 Health NYCRR section 766.4 – Medical Orders (5/31/00)
- MOMS Policy Manual – Section II, Policy for Client Admission, Plan of Care and Discharge

Original: 8/24/12
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Inclusion Through Diversity

Community Health Quality Assurance Committee Approval: ~~pending~~6/18/13
Board of Health Approval: *pending**7/9/13***